SIGNS OF THE TIMES

Community Health and Development Program
The Community Health Department of the
Christian Medical College, Vellore.

By

Gillian Paterson

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But you cannot interpret the signs of the times.
Matthew 16:3

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FOREWORD

The "Signs of the Times" is our second attempt to capture the different links in the chain of events and the efforts of many who have toiled to make Community Health And Development, fondly referred to as CHAD, what it is today. It is but apt that it has been possible to publish this valuable document 50 years after the department saw its beginning as a small but relevant initiative in healthcare and for training healthcare professionals for the nation.

It is our hope that "Signs of the Times" will prove to be a useful reference for all who are interested or involved in health and development. As we look back at the events of these fifty years, we are aware that though there have been impressive strides, much more needs to be done and there are several exciting challenges before us.

Dr. Ida S. Scudder, CMC's founder, called on her successors to pass on her 'torch of life' to generations to come. CHAD's team is committed to this ideal. None of what has been achieved would have been possible had it not been for several visionaries - Dr.K.G. Koshi, Dr.V. Benjamin, Dr. Sojibai Samson, Mrs. Achyamma John, Dr. Abraham Joseph and now, Dr. Sulochana Abraham and her team. The commitment and hard work of the entire CHAD team has been vital for the enviable success of every endeavour. Above all, God Almighty, the architect of all plans has been with us all along.

We have, in the CHAD experience, an excellent model for the nation. With the country poised for exponential growth, I hope and pray that our leaders will introduce the CHAD model in several parts of the country. The emphasis of the present government is on the health of the rural population, the poor and the marginalized. CHAD has shown us the way to respond effectively to these often neglected segments of society.

We are deeply indebted to Ms. Gillian Paterson who authored the first booklet on CHAD - "There rest thy feet", for carefully reviewing and thoroughly researching all the available material and evidence and for her persistent and tireless efforts in producing this document. We would like to place on record our heartfelt thanks to Mrs. Usha Jesudasan for giving of her time unstintingly to edit this book.

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THE OLD IN THE NEW

'I am uneasy at heart when I have to leave my accustomed shelter; I forget that there abides the old in the new, and that there thou also abidest.'
Rabindranath Tagore: Gitanjali LX111

'Vellakara amma'

The year is 1900. It is dark, but not quite as dark as it was. A tree takes shape, then a pale patch where the road is. Far away, a jagged streak of silver defines the crest of a range of hills. Into the silence, a single bird sings out, then another and another, until the not-so-darkness is alive with song. Pale fingers of light, stretch like searchlights, up the velvet sky. These falter, spread, turn to pink, red, and then a triumphant gold. Slowly, a millimetre at a time, the sun detaches itself from the grotesque silhouette of the hills, light spills over onto the plains, and the dawn has come. There is a distant clanking, the sound of voices, and a bullock cart clatters into sight, bearing a group of women huddled inside their shawls against the morning chill, and a clutter of boxes and bags.

Under the big tree, a gaggle of people is already gathering: a girl (little more than a child) crooning over a withered scrap of a baby; a young man with a huge, bloated leg; an ancient woman with blind, filmy eyes; a dignified old man with one leg. A little apart is a small, tattered band whose hand, foot and nose lesions betray them as leprosy sufferers. The bullock cart clanks to a halt, and the able-bodied surge round it, ready for the roadside clinic held every Thursday morning, under this tree.

Over a hundred years later, there are still people who claim to remember those early 'roadsides' and the *vellakara amma,* the white woman doctor with the big smile: Ida Scudder, founder of CMC, the Christian Medical College, Vellore. The bullock cart was eventually replaced with a car (the first in Vellore). Hat firmly on her head, 'Aunt Ida' would hurtle along the dusty tracks. On the way out, the car would be laden with staff, medicines, instruments and sterile dressings. On the way back, patients needing hospital treatment might be settled on the laps of unsuspecting visitors, while the younger, fitter members of the party would travel on the running board. Of course few now can really remember this sight: but many believe they can, because Aunt Ida and her work have passed into the mythology not just of Vellore but of the whole of North Arcot district. The difference is that today, they are more than far off visions, more than myths: they have become the reality.

An interface

Based at Bagayam, about 5km from Vellore Town, CHAD is the Community Health and Development programme of the Community Health Department of CMC. As such, it has two main objectives. It provides primary health care for a population of nearly 250,000 in the nearby rural, urban and tribal communities; and it provides training in the principles and practice of community-based health care for medical, nursing and paramedical students, post-graduates and staff from CMC itself. Founded in 1954 by Dr K G Koshy, CHAD was then a simple clinic-based, coordinating centre for the rural teams. In 1957, a 12- bedded hospital was built, and in 1982, in response to increased demand, the number of beds was increased to 80. Social and economic development programmes were added in 1977, and in 1995 the Community Health Training Centre was inaugurated. The next project is to build additional surgical, midwifery and outpatient facilities.

So CHAD today is a big and complex operation, a far cry from the base clinic that opened in 1954. But Ida Scudder's dream is still at the very heart of its vision and motivation. This outspoken woman was thoroughly impatient with young people who thought practising health care meant sitting in a clinic waiting for the patients to come to them. From the word go, it was clear to her that the roots of health lay not in the hospital but in the local town or village community where people lived. In this, she was way ahead of her time. Today, there is national and international recognition of the need for primary health services to move out of the hospital and into the community. The notion that health is something that can be handed out in a clinic to passive and grateful recipients is – at least in theory – a thing of the past. Nor do we any longer believe – at least in theory – that the health of the community is simply a matter of improved medical services. All the medicines, iron supplements and immunisations in the world will not help if a family has nothing to eat, no income and no marketable skills.

So the world has moved on. National and international health care goalposts have moved too, along with the systems and expectations that go with them. Health is increasingly seen as a global issue. Technological innovation and the communications revolution have transformed the face of medical education and of the modern hospital, and in turn, the significance of community health within the medical curriculum. The need for cooperation between government and non-government sectors is increasingly acknowledged. India and its needs have changed massively, with increased urbanisation, the growing number of old people, the widespread disintegration of the extended or 'joint' family, and the onward march of consumerism. These factors, in turn, have impacted on the career expectations of young health professionals.

Dr Abraham Joseph, affectionately known as 'Uncle', was Head of CHAD from 1982 to 2002. Passionately committed to the principles of community-based health and development, he was also conscious that CHAD was situated at a crucial interface between all the above factors. There was the potential, he believed, for the Community Health Department to develop cutting edge programmes that genuinely moved with the times, responded to need, engaged with global influences, and offered young health professionals an opportunity to acquire national and international perspectives as well as local ones. In this he had the support of an unusually talented and enthusiastic team, many of whom we will meet in the coming pages.

The growth of CHAD, along with its programme of national and international links and training, is being maintained and further developed by 'Uncle's' successor, Dr Sulochana Abraham. "We could have done none of this," says Dr Sulo, "without our core group of administrative staff." Samuel, the office administrator is in some ways the lynchpin of the organization. He has worked at CHAD since 1982, and his colleagues Arokia Mary and Sumithra not much less. "It has been such a privilege to see this vision coming to life," says Sam, "and to be so completely involved in every part of it. This place is not hierarchical. We are all part of the team. It doesn't matter if we're drivers or consultants: we're given responsibility, we're trusted. And we're proud of it."

The old in the new

Many of the issues discussed in this little book are ones that confront anyone who is working in community health, or at a decision-making level in medical education. Its primary focus, though, is the way in which one particular programme - CHAD - is tackling them, involving one particular group of people working in one particular location. Chapters 1 to 4 will look at education and training, health service delivery, development and research. In Chapters 5 and 6 we will meet some of the people who have gone through the CHAD training, either as students, as interns, or as young professionals, and are now engaged in mould-breaking work elsewhere in India, or abroad. What do they owe to their time at CHAD, and what in particular have they taken from the CHAD experience into what they are doing now? In the final chapter, we will explore some of the challenges this programme (and to some extent any programme) faces as it moves into the future, and see how it plans to meet them.

But how does it feel, to be confronted by this cauldron of movement and change and apparently conflicting demands? Confusing? Unnerving? Alarming? Well, it would be possible to feel any of these emotions. 'And that,' says Sulochana Abraham, 'is why it is so vital for us to remember our roots, our faith, and the vision that inspired this institution long before any of us were born.'

Chapter 1

EDUCATION AND TRAINING

"Primary health care cannot be taught in a vacuum."
Dr. Abraham Joseph

Life out of death

Ida Scudder's story is legendary. The daughter of medical missionary parents, Ida longed to escape from India and go back to her life in the USA. Alone at home one night, she heard a knock on the door, and there stood a young Brahmin. 'Ma'am, you must come,' he said. His wife was at home, in labour, and everything was going wrong. 'I'll call my father,' said Ida. 'Oh no!' was the reply; 'that is out of the question.' In that culture, the young wife was better dead than seen by a male doctor. Couldn't she come herself? But Ida had no training. She would be worse than useless in such a situation.

The visitor was followed by two more young husbands: a lower caste Hindu and a Muslim, their wives in childbirth, and with terminal complications. In the morning, the drums and the wailing told their own tale. All three women had died in the night: and it could so easily have been prevented.

Beside herself with rage and grief, Ida had a revelation. Medicine in India at that time was an almost entirely male preserve. For the women and children of India to have the health care they deserved, the really desperate need was for Indian women to qualify as health professionals. She, Ida, would go back to the USA, qualify – like her father and brothers – as a doctor, and come back to India to set up a medical school to train women nurses, midwives and doctors. And so the vision was born: the vision that gave birth to the Christian Medical College Vellore, and eventually to CHAD.

Since 'the night of the three knocks', when CMC was little more than a young woman's dream, education and training have continued to be at the very heart of its mission. But the education of health professionals cannot be divorced from practice. Students wanting to take their place in the world of medicine today, need the context of a first rate tertiary hospital, with a range of specialties. Outstanding students and postgraduates want to work in centers of outstanding curative and scientific excellence (of which CMC is one). The problem is that the hospital environment is far away from the context in which the majority of people face the challenge of keeping healthy: a distance that is increased by the growth

of technology, the increasing concentration on science as a basis for clinical decisions, and the high status accorded to specialization. In addition, the majority of students come from middle class backgrounds. Never in their lives have they been exposed to a poor village or an urban slum. When the context of the work is so alien to the experience of the students, classroom teaching becomes virtually meaningless.

This is a major challenge for medical education, a fact that the Indian government recognized as early as 1977, when it launched its Reorientation of Medical Education (ROME) scheme. For twenty-five years or more, the government has been urging medical schools to give equal emphasis to the teaching of primary health care. At state level, community health is a major curriculum priority, and is expected to take place in the context of real communities. Today, each medical school is required to take responsibility for a rural population of at least 100,000 and an urban population of 30,000.

At CMC, this principle has never been seriously questioned. For Ida Scudder, a century ago, the 'roadsides' and the home visiting programs in Vellore Town were a core element in medical education. But in the early fifties, when tertiary services were beginning to expand at CMC Hospital, it began to look as if the original commitment to taking health care to the poorest people might be lost. In 1954, the Community Health Department was founded; community health became a compulsory element in the education of nurses and medical students, and CHAD was born.

Why go into community health?

The excitement of clinical and scientific approaches to medicine is an important dimension of training at CMC. To the specialist, tertiary medicine is challenging, and it has high status. If you want to make money, that is where you should be. Regrettably, though, the apparent polarization between tertiary and primary health care, referred to in the introduction, has sometimes given the impression that you have to choose between them. So why do bright young people opt to work in CHAD?

A gala time

Dr Anuradha Rose is a senior registrar at CHAD. Trained in community health at CMC, she did her MD in Public Health at CHAD. Some people don't enjoy their time in primary health, she says. They don't like getting bogged down in people's personal problems. But for Anu, her first experience of CHAD was a very good one. 'I am basically a small town person, and I value the personal.'

She loved the hands-on relationship with families. The N/19 program is a club for mothers with malnourished children, who live in the hospital for a period of time so that the women can learn to cope better and the children can recover. A gloomy, cave- like room had been set aside as a playroom for the children, and as an intern, an intern, Anu tried to spend a bit of time every day playing with them. But it was a depressing place. The highlight of her three months as an intern was the day she and her friends stripped it down and painted the walls with bright, cheerful Disney characters. Night came, and they realised that there was no electric light in the room. 'Emergency lighting!' they said, and raided the operating theatre. By dawn, it was done. 'That experience changed my outlook,' she said. 'I realised that it was possible to change things so that they were better for people, and I also realised that it was really fun.'

So overall, how did she rate being a student and an intern at CHAD? 'Oh,' she says, 'I had a gala time.'

70% of CMC graduates go on to work in mission hospitals, and Anu is no different. Her MD completed, Anu and her husband have left CMC to return to the rural outstation where she did her bond. The place is collapsing; the bathrooms don't function; the clinic is derelict. It will be a struggle.

But times are changing. Anu is totally committed to building up her crumbling mission hospital: it is the life that, for the moment, she has chosen. But training in public health or community health, today, can equally well open the door to prestigious appointments in international agencies. The image of the community health professional is no longer that of the isolated generalist in an inaccessible, dilapidated rural clinic, doing everything for the patients with few resources. On the contrary, a doctorate in public health or community medicine (which Anu has) can be a passport to desirable and interesting jobs. Many nursing and medical openings nowadays demand some community or public health experience. In tuberculosis control alone, the new requirement in India is for 150 designated medical officers in every district. There is an increasing demand from tertiary hospitals for research on health questions that can only be answered at the level of community. As a result, more people working in tertiary care facilities are finding that they need training in epidemiology, community-based research methodologies, or the philosophy and practice of primary health care. More and more, it seems, it makes sense for hospital and community to be taken as an integrated whole, and the market value of a qualification in public health is going up all the time.

CHAD has responded to this situation by expanding its post-graduate program, and by setting up courses in epidemiology, health economics, primary health and community-based research for its own faculty and for health professionals and scientists from other parts of the Indian sub-continent and beyond: all of which indicates a major expansion of CHAD's training role, and suggests that the demand for its courses will expand still further in coming years. So the balance of CHAD's work is changing. The health and development programs remain at the heart of its service role, they make a reality of its Christian calling, and for people living in the surrounding areas they are the main reason for its existence. But as far as CMC is concerned, the primary justification for the programs' existence is the role they play in the education and training of health professionals. As CHAD's former Director Dr Abraham Joseph says, 'Primary health cannot be taught in a vacuum.'

'A kind of awakening'

Medical students first encounter community health when they do the Community Orientation Program at the end of their first year, after the first year exams. COP consists of a three-week block posting for medical, physiotherapy, occupational therapy, dietary and bio-statistics students. First there is an introductory module, and then they all go to live and work for two weeks in one of the villages of Kaniyambadi block.

COP

Imagine. It is dawn, the last star and the crescent moon a faint glimmer in the west. In the village, the fires are already lit. Women converge on the well, shining brass water pots balanced on heads or hips, while small children stumble out to the fields to relieve themselves after the night.

A tall, bent old man with a single tooth totters down the road, out for his morning walk. He meets a little knot of medical students and stops to harangue them. He has a bone to pick with them. Yesterday, he was prescribed some medicine at the village clinic, but every time he takes it, his cough gets worse. The students listen sympathetically and ask a few questions. An intern who is with them gets out a stethoscope and listens to his chest. He delves into a pocket and produces a note: although he can't read it, this is the chit referring him to the CHAD Hospital tuberculosis clinic. Five minutes chat, laughter all round and the group continues on its way.

At their first COP, students complete a proforma designed to show how people live, and how they feel about the world. This is followed up with a biomedical survey, whose

results they have to collate. They learn to draw water and dig soakage pits, and girls and boys alike are expected to become familiar with the camp kitchen. On most days, specialist staff from the College visit, in order to explore with the students the implications of this experience for their own specialty – obstetrics, perhaps, or orthopaedics. Government officials come to speak about relations with government structures.

In the group work, students identify the problems of the villagers, then design a health education program to deal with the one that seems to them to be most pressing: for instance, one group might opt for alcoholism, and another for environmental sanitation.

Using appropriate sampling methods, they also conduct an in-depth investigation of a specific common problem – anemia, hypertension or tuberculosis, for instance - gaining experience in interviewing, and in conducting simple tests under village conditions. Blood and sputum samples are sent back to CHAD Hospital for testing, and cases identified are referred to the camp clinic.

With the help of the staff, the students process the data they have collected, and the statistical analysis techniques taught earlier in the course are now put into practice. Great care is taken to see that data is collated in such a way that the findings of the various surveys are relevant and useful in the village context. The results are presented and discussed by all students during a two-day session after the camp is over.

Every evening, villagers are encouraged to bring their problems to an outdoor clinic, which treats cases referred during the day. They may refer patients on to base hospital for treatment. This clinic always attracts a good audience, and provides an ideal opportunity for health education among those who attend it. Towards the end of the camp, the students present special case studies of individuals suffering from common illnesses, which they have identified themselves. In addition, students conduct dramas and skits on such subjects as alcoholism, nutrition and family planning, and at the end of the fortnight they put on a major display covering nutrition, immunization, family planning, sanitation, common parasites, malaria and so on, based on the findings of the survey.

COP - Clinic

It is now midday. A couple of medical students – well-dressed, anxious young women – are picking their way down the rutted street towards a member of staff. "Ma'm, Ma'm!" they call out urgently. "Come quickly! There is a sick child!" The child is indeed very sick: a four-year old with a high fever, struggling for breath.

The pharmacist in the next village has given the mother a bottle of tonic costing Rs 60/-. But the child needs to be in hospital. A long dialogue follows. The mother doesn't want to take the child. She has a two-year-old who won't be left with the grandmother, and a deaf and dumb daughter aged six. She has no money for the bus. Finally they all set off down the track to the COP clinic.The mother is carrying the sick child; the six-year-old is carrying the howling boy, her skinny legs buckling under his weight.

For many students, this is an electrifying experience. One faculty member tells of how his student son reacted to his first COP. "He identified this sick woman," says the father, "and she was admitted to CHAD Hospital. So as soon as she arrived, he went to visit her and bring her food. But he was horrified because she had nothing to make her comfortable, so he came home and took the new bedsheets and pillow we bought when we were working in the States, then went back to the ward and put them on her bed. I have often tried to imagine what the patient thought of this."

Finally, the week culminates in a wonderful musical and dramatic event, which is chaired by village leaders, and in which students and villagers take part. Everyone comes, and everyone has fun. Above all, COP's most memorable quality is that it is enjoyable, and students and villagers alike are often sad when it is all over.

One ex-CMC medical student described his first COP as 'a kind of awakening'. It was more than just an awakening to an unfamiliar concept of medical care: it was the dawning of light on the half-feared and the half-known; the harsh, but rich and diverse reality of the lives of the vast majority of his fellow Indians. "It was my first COP that sparked off my interest in community health," said one young woman, now working in a rural area in the Northeast. "I realized then that this was the kind of medicine I wanted to do." All over the sub-continent, you will find CMC graduates working in difficult and out-of-the-way places. When you ask them when they opted for this kind of life, many of them look back at their first-year COP and say, 'It was then'. We will meet some more of them in Chapter 5.

CMC alumna Dr Chitra Stephen sums it up. "To tell the truth," she says, "I had considered it just a fun time away from the books till the day I saw my city-bred classmate from Delhi sitting cross-legged in a small hut in Senji, surreptitiously wiping away a tear as a young woman spoke of the three babies she had lost. Looking back, I must be honest and confess that COP was little less than a time of unadulterated joy for me."

Working on your own

The second phase of the Community Health Program takes place in the first clinical year, when students are introduced to principles of epidemiology and health management and familiarized with government health programs and the way they work. It includes field investigations of how those services operate, made possible by CHAD's close relationship with government services in the area. Some students go into this module expecting it to be just like COP all over again, and feel let down when they find it is more classroom orientated, with the inevitable donkeywork involved in acquiring methodological skills and knowledge of systems.

In the second clinical year, there is a further two to three week posting. The students are divided into groups of five or six and are asked to make a community diagnosis of a particular problem within a defined area, and then plan and implement a community health program that uses the data collected. Topics covered may include immunization, family planning, relations between CHAD and government services or the organization of community-based maternity services. To do this, students use the staff and resources of CHAD and are encouraged to call upon members of the health team as required. Many students say they find this the most satisfying of all their student postings. It enables them to work on their own in the field, and they can see what they have learnt on previous assignments coming together in a way that is practical, relevant and useful.

The final phase of community-based training for most graduates is the interns' program. CHAD has twelve to fifteen resident interns at any one time. Out of the one-year compulsory internship, three months must be spent with the Community Health Department, the aim being to teach them the attitudes and skills to work as 'basic doctors', with practical knowledge and experience of community health practice. This involves being able to diagnose and treat common complaints without the use of sophisticated equipment, and learn when to transfer patients to specialist or larger hospitals. They must also perform simple surgical procedures such as tubectomies, assist at caesarian sections, and do simple laboratory tests. Interns conduct outpatient clinics, under the direction of a senior doctor. They spend two weeks in a CHAD Hospital ward, where they are responsible for the general management of post-operative patients and others requiring admission.

They take part regularly in the rural and urban clinics. They are part of the leprosy teams and of the mobile clinic teams that support the Part-time Community Health Workers and health aides. Most of all, they learn to view the patient not as an isolated individual

with a clinical disorder, but as the 'sign' of an environment that is physically, environmentally and socially sick. Community disease cannot be treated by medical means alone. Poverty poor agricultural practice, inadequate sanitation, superstition and illiteracy: they are al barriers to a healthy community. Interns are encouraged to become involved with CHAD's developmental activities and to talk to local people about their lives in general.

Regular seminars are held. Interns present studies of particular areas of CHAD's work leading to exchanges that uncannily echo the dialogues taking place in the journals and conferences of the worldwide medical establishment. Examples include the pros and cons and the practical implications of community-based rehabilitation, the desirability of socio-economic programs targeted specifically at women and the ethical dilemmas presented by the HIV/AIDS epidemic. Grappling with dilemmas like this led to the setting up of the Ethical Case Review, which has become such an important element in CHAD's education program.

For a few students, the community health internship is something to be endured, an unwelcome interruption to the 'real' life that is taking place at the main hospital campus. For others, it is a joy. They love being out of the noise and dirt of town and the anonymity of the hospital campus; they are excited by the work and the independence it gives; they enjoy getting to know patients as real people with real lives, rather than as clinical cases encountered in a hospital. They like working in the smaller unit, with a friendly, informal committed team. Above all, they like the freedom it offers to be creative, to have ideas and act on them.

Conflicting principles: the ethical case review

It's 7.30 in the morning, and around 40 people are crowded into the upstairs classroom in the Community Health Training Centre. Early birds are sitting at the tables, but latecomers are perched on tables and window-ledges. Now it is standing room only. The group consists of CHAD faculty, interns and nurses, development staff, social workers and counselors, faculty from the Psychiatry department next door, plus half a dozen Swedish medical students and their leader.

Today's case study is a tuberculosis patient on a DOTS (Directly Observed Treatment Short-course) program. A married man of 59, he has repeatedly defaulted from the treatment regimen. There have been numerous efforts to support him, to bring the treatment nearer to his home, to be flexible in delivery. None of it has worked; but he

still comes back, a few months after defaulting, and asks for the treatment to be resumed. Now he has multi-drug resistant TB. He is a danger to himself, his family and the wider community. What to do? If drugs are refused, does that count as killing? In Sweden, chronic defaulters are locked up and made to take the drugs until they are better. But what about individual rights and the principle of taking responsibility for one's own actions? On the other hand, the general public has rights as well. Why should one person be allowed to go around infecting others? TB is associated with poverty and alcoholism: has the DOTS program done all it reasonably can to help? In this context, what constitutes 'reasonable'?

CHAD's program of ethical case reviews is coordinated by Dr Shantidani Minz. At CHAD, she says, these reviews were initiated by Dr Sulo as a result of the regular auditing of hospital data and the dilemmas that emerged. Sessions now occur about once a month. The HIV/AIDS epidemic presents especially complex dilemmas. Take confidentiality, for example. A blood donor from the North east comes to Vellore wanting to give blood for his sick relative. When routine testing of the blood reveals that he is HIV positive, the physician informs not just the blood donor himself (who has no idea of his condition) but also the patient and his doctor. Rules of confidentiality have clearly been breached. On another occasion, less clear-cut, a recent widower is tested for HIV and found to be sero-positive. Some weeks later, staff learn that he is planning to marry his dead wife's sister, but without revealing his HIV status to her or to the family. This is much more difficult. Should they intervene by telling the family, or should they just sit back and watch the girl going into a situation that might very well lead to her death? Since then, the government of India has ruled that the public good comes before the individual good, and in such cases the law of confidentiality can be lifted. But these are agonizing situations, and in their time have been vigorously discussed at the ethical reviews.

It is astonishing, says Shanti, how much time people are willing to spend preparing for these sessions, in terms of reading around the issue and establishing what the law says about it. In India, it is not usual for medical colleges to have organized teaching on medical ethics, or specialists in medical ethics on the staff, but she thinks this is an essential part of medical education. It is vital for young health professionals to learn the importance of establishing the facts before making ethical judgments. She feels interns and students gain enormously from hearing the range of positions held by the people they knew, and from the experience of bringing some of the most painful dilemmas out into the open. It doesn't matter if there are wide differences of opinion: the important thing is for them to be named, heard, and lived with.

Nursing

Community health plays an equally important role in the education of nurses and nursing students. CHAD's MSc, BSc and Diploma courses all have a substantial community health element, and the College is now in the process of setting up a Master's qualification for family health practitioners. This will be the first course of its kind in India, specifically designed for those who want to serve in areas where there are no doctors. So all nurses at CMC get major exposure to community health training, much of which takes place at CHAD. CHAD has also been running the 'clinical skills' element in the MSc Nursing training programme - one of only four such courses in India. Every MSc student does a four-week posting in CHAD, and community health specialists do more. In the second year of the course, they conduct a piece of research and write a dissertation based on an urban or rural situation.

CMC has two basic nursing qualifications, the BSc and the Diploma, which take four and three years respectively. Both courses include an increasingly substantial community health component, block placements being divided between CHAD, RUHSA (the Rural Unit for Health and Social Affairs in K.V. Kuppam block), and the urban program, where they collaborate with the government set-up. CHAD is not the only place in CMC where nurses can get training in community health. In addition, the College of Nursing runs its own program, CONCH (College of Nursing Community Health), which is managed entirely by nurses. LCECU (the Low Cost Effective Care Unit has a secondary care hospital in Vellore Town with some outreach work.

So nurses in training may spend from fifteen to twenty weeks at CHAD. Here they experience a working environment that integrates the primary and secondary care with development work, and with the other services that CHAD provides. CHAD's nursing education program is responsible for the training needs of primary health teams that serve the rural area, and for the development of health education programs within the villages. As part of their training, all nurses are exposed to this work, and to the experience of working as part of a team consisting of nurses, health aides, and part-time community health workers or PTCHWs, often working in collaboration with the leprosy teams and the extension and development officers. They also learn the key role played, in primary health care, by socio-economic and development programs.

On all these courses, the emphasis is on practical experience. Students go out with the mobile health teams, assisting at PTCHW clinics and doing home visits with the team. They learn how to treat mothers and children in their homes, and they learn their domiciliary

midwifery with the help of the CHAD health teams. In the base hospital, they conduct deliveries, and assist at tubectomy operations and at the insertion of the 'copper-T' intrauterine devices.

Sister Alice Augustine is Nursing Superintendent at CMC. When she was a trainee nurse, she says, community health was not popular. Young women wanted to be on the main hospital campus in town, and had to be cajoled and bribed into going to CHAD. Today it is different. Community health is becoming an increasingly popular option. Even those nurses who want to work in more specialized fields are keen to do at least one year of community health nursing, believing that it will greatly increase the range of jobs they can apply for. They find they can use the experience anywhere, and for those of them who are going on to work in mission hospitals, much of what they learn can be transferred to the new context.

Sr Rosaline Jayakaran is a Professor of Community Health Nursing at CMC. Not everyone likes community health nursing, she says. It depends on you. For her, she loves the rural work, and she loves the independence. When she was young, she loved living in the big, friendly nurses residence with its lovely garden. She loved working as a member of a small team where you can largely set your own agenda. In hospital, you are dependent on the doctors for directions. In the community, you are your own mistress: you work in your own way and make your own decisions.

Rapport and research

To do community-based research, you don't need a white coat: what you need is initiative, independence of thought, and rapport with people. Chitra Paul entered CMC as an open student, because she didn't want to be tied down to the obligations that come with sponsorship. She trained in the College of Nursing at CMC, became a staff nurse at CHAD, and did her MSc at the College of Nursing. Her thesis was a study of health-seeking behaviour among commercial sex workers in an urban slum in South India: research that she was invited to present at the 12 th World AIDS Conference in Sweden, in 1997. Wanting new challenges, she left CMC for Nepal, where she worked at the BP Koirala Institute of Health Sciences in Dharan. Here she earned huge respect by going out into the tribal areas, staying there and conducting deliveries with the trainee nurses, and carrying out groundbreaking research on the HIV status of prisoners and their problems. Wanting to develop her research experience and professional qualifications further, she has now - to BP Koirala's great sadness - decided to go to the USA and get her PhD, before coming back to India to work with its people.

National and international

As Head of CHAD during the late 'eighties and early 'nineties, Dr Abraham Joseph was often invited by international bodies such as WHO and the World Bank to carry out consultations in community health education, not just in other parts of South Asia, but further afield as well. For the first time, he realized what strengths they had in CHAD. In Bangladesh, Nepal, Vietnam – very poor countries with, at the time, a weaker health care infrastructure than India - he kept thinking about just how much his own Community Health Department had to offer to health professionals struggling to make a difference in these situations. Why not run training courses, involving field work, to enable such people to get away and reflect on their work, review possible solutions, and see how it is done elsewhere? Over the same period, he paid a number of visits to medical schools in Europe and North America. There, he found international and public health being taught according to principles that were classroom-based, theoretical, and involving very little field experience. Why not invite such institutions to run some of their courses in CHAD, where they would be able to combine research and service elements with the practical experience that can only be acquired in the field? Out of these insights, the Community Health Training Center (CHTC) was born, the gift of the Danish Government's development agency DANIDA. Today, CHAD regularly welcomes groups from all over the world. The CHTC guesthouse, with its friendly service and excellent South Indian food, has an international, all-age clientele, and on any one occasion you may hear up to five or six languages being spoken.

In recent years, CHAD's training role has been increasingly acknowledged on the national, regional and international stage. At the regional level, it is a nodal center for training in reproductive health for the states of Kerala and Karnataka. For WHO, it runs courses in district health systems. Now designated a WHO Collaborative Center for Community Based Professional Education, it is responsible for a large number of courses in community-based education, attracting groups from Sri Lanka, Thailand, Indonesia, Myanmar, Bangladesh and Nepal. None of this would have been possible without the vision and unremitting effort of Dr Abraham Joseph. In the words of Dr V Benjamin, former head of community health, 'When this little man joined the community health department, little did I dream that he would put it on the world map.'

Governments and international agencies increasingly stress the need for epidemiological training: and yet few medical schools have departments of epidemiology. Every year, the department conducts a two-week training program in basic epidemiology, and another in

advanced epidemiology. These courses are open to faculty, but also to health professionals from all over India. They are always massively over-subscribed, turning away four times as many applicants as they can take, and it may soon become necessary to increase the number of basic epidemiology courses to cope with this situation. It's interesting that all senior faculty from CMC have attended one of these courses.

What can we learn from India?

In Europe and North America, medicine has become increasingly hospital based and divorced from communities themselves. This makes it very difficult for young health professionals to understand the health care challenges experienced by most of the world. It also deprives them of a working understanding of community-oriented health care in their own environment. At the same time, the huge disparities in health care provision between the North and South are a cause for concern, with more and more universities and schools of public health setting up courses in global medicine or international health. In addition the big international agencies repeatedly stress the importance of thinking and acting globally in health matters, and place a high priority on collaboration with institutions of proven excellence in the South.

Uppsala University's Global Medicine module has been running since 1994. It is an annual five-week course for pre-clinical and clinical medical students, involving three weeks in Uppsala and two weeks in a low-income country. Half the participants go to an African country; the other half (normally about 25 of them) come to Vellore. Gunnar Holmgren is coordinator of the course. Vellore, he says, is an ideal place to come. It gives students an insight into four different levels of medical training. They see the high-tech medicine and surgery practiced at CMC Hospital. They do ward rounds and observe deliveries at the secondary hospital, CHAD. They see how primary health care operates. And by getting involved with the community based socio-economic and environmental programs, they learn the connection between health and development.

This turns out to be a unique experience. They are deeply impressed by the commitment of the staff. 'You won't believe what we have done today,' they say. Six years on, many students have said that of everything they did in the course of their medical training, it was this experience that had the biggest impact. It didn't just widen the horizons of their medical knowledge: it changed them as people, and made them understand things about the world that they could never have learned in a classroom in Europe.

Gunnar sees the Sweden-Vellore link developing in four ways. The Global Medicine course is the first. The second is what the Linnaeus-Palme exchange program, which links Swedish universities with universities in the South. 'In Sweden,' says Gunnar, 'we tend to think we are the best. What can we possibly have to learn from India? But people who have come here cannot have that impression. They often cannot believe the quality of the clinical teaching. The main problem is, how to find something to show them when they come to us. The reality is that Sweden needs the world more than the world needs Sweden.'

The third linkage involves CHAD faculty input into courses in Sweden, particularly in the field of maternal and child health. The fourth is a research link, involving final year students, postgraduate nurses and newly retired doctors. The aim is to encourage minor pieces of community-based research in developing countries. It is a major problem, in Swedish universities, to get people to do research: but here they have the analysis, the statistics, the thinking. Examples so far are how they brought down maternal mortality in a specified area, and how new ways of doing caesarian sections worked in this environment.

Also, Gunnar is an inspiring teacher. At 7.30 one morning, he delivers a lecture, entitled 'Survival of the Weakest', to faculty and health staff at CHAD. The subject is symphisiotomy as an obstetric technique. Does it produce good results in a resource poor setting? Yes. Do they use it in Sweden? No. And so on.

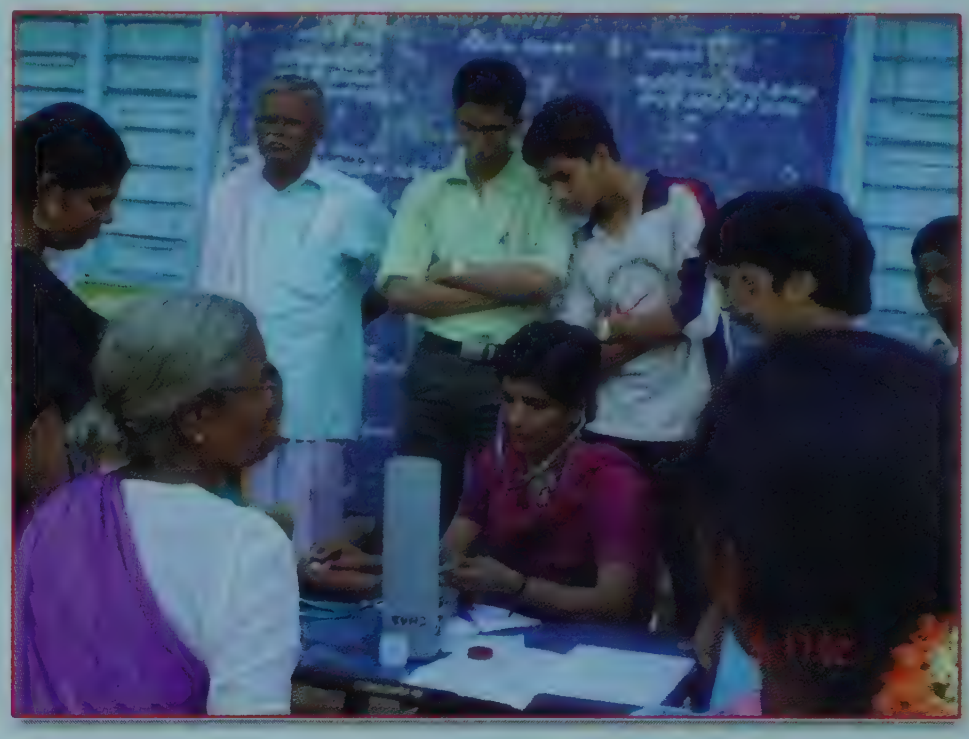
CHAD is therefore collaborating with various European and North American universities in providing training in public health methodologies for their students, and in offering field experience to their students. The annual five-week visit to CHAD now forms a regular part of Copenhagen University's Masters' program in international health, as well as Uppsala University's Global Medicine Training Program for undergraduate students. CHAD welcomes public health students from Ben Gurion University in Israel. It has run courses for Ohio University and Concordia College in the USA, one for social work students the other for students of development. It is part of its plan for the future to expand these programs further. At the moment they do not have the space to do so, but they are a priority consideration in future building plans.

This focus is consistent with CMC's understanding of itself as an international institution. It also witnesses to its belief that the message of a Christian institution must be one of hope. It is a common experience for visitors to poor, struggling communities to go away with a sense of hopelessness, and a feeling that the problems they have seen are so huge that there is no answer to them. Such a view reduces primary health care to a sort of patching-up operation on a vessel that's sinking anyway. Because of the presence of CHAD,

no CMC graduate, nobody who has gone through one of the training courses described above, can go out into the world without rethinking such a view. They don't just learn about problems, they learn about solutions as well, and how to implement them. And by the time they move on, every one of them has experienced a model of community health and development that is professional, practical, based on experience, and above all, which really does result in an improvement in the health of poor communities.

'Tell me - I will forget
Show me - I may remember
Involve me - I shall understand'
(Ancient Chinese proverb)

Students learning to interact with Villagers

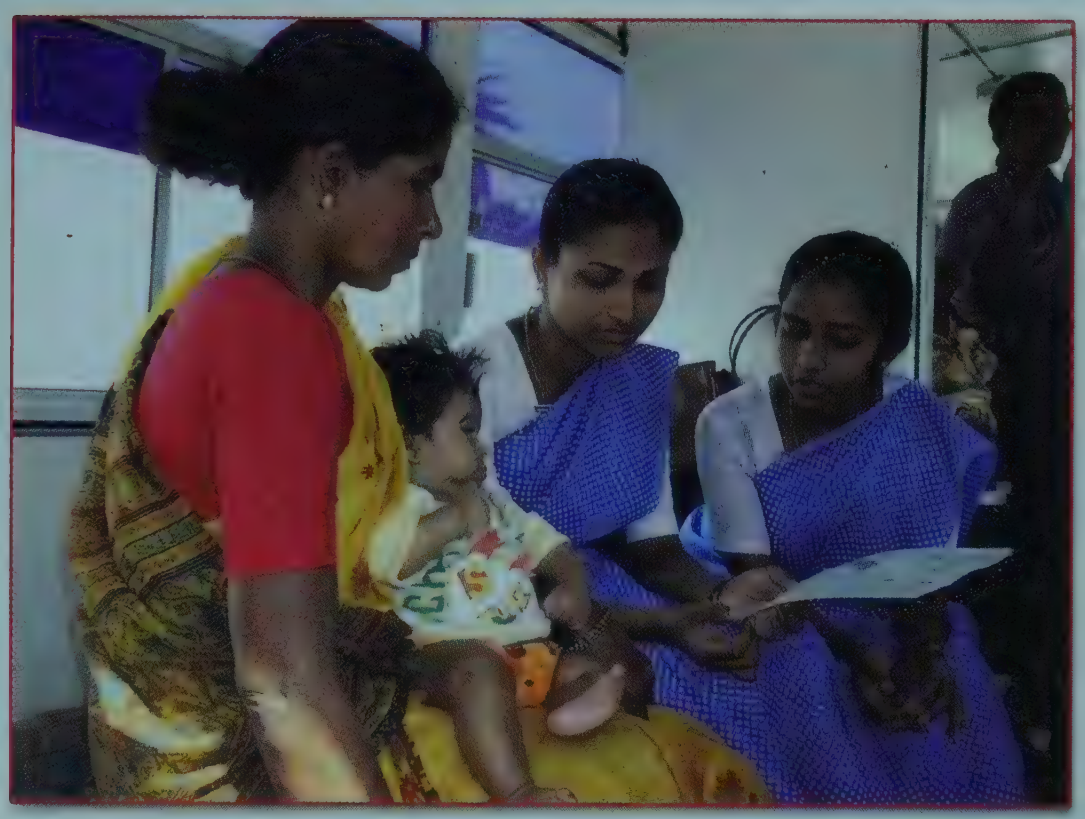


A typical COP Clinic with students paying attention

Students entertaining the community during COP

Health for all

At a peripheral
PTCHW clinic



Nursing students
learning to care

Chapter 2

HEALTH FOR ALL

'Not to be ministered unto, but to minister.'
Motto of the Christian Medical College, Vellore

Mobile clinic day

It is cool, the morning mist promising heat to come. Tomorrow is Pongal, the South Indian harvest celebration that occurs every January before the heat of summer gets going. Outside CHAD Hospital, staff are busy preparing the mobile clinic for a day out in the villages. Priya Roseline, the public health nurse, is loading medicines, sterile syringes and patient records into the van. Dr Ann Mary Augustine, the intern, arrives to check the departure time. The registrar appears: Dr Anandanayagi deep in conversation with a colleague. A gaggle of white-coated occupational therapy students swarm in and settle in the back of the van; the driver climbs in and starts the engine; and then we wait. And eventually Greeta, the health aide comes puffing into the yard. The children are out of school today because of Pongal, and she's had a rush to get here on time.

Soon we are trundling along the dusty road that leads southward into Kaniyambadi. The road is shaded by tamarind trees: tamar-al-hind, 'the Indian palm tree'. Beyond them stretches the plain, with its ploughed fields, its pale, feathery sugar cane, its brilliant green patches of paddy. But the rains have been poor this year, and the paddy fields, more often than not, are dried up and brown. The road runs between angular mountains. They have scrubby forest on their lower slopes, but the tops look like giant, granite sculptures against the shimmering sky. These are the foothills of the Jawadhi Hills, stretching from the far end of Kaniyambadi block, some 150 Km to the south. There are people everywhere, driving goats, tending cows, watching their children play, bouncing over the rutted tarmac on two wheelers or bicycles. Animals too. Many houses have a cow tethered in the yard, and we swerve occasionally to avoid a herd of goats being driven along the road.

Sholavaram is a big village, and because today is a holiday, it is swarming with people. We turn off the road into the main street, and there on the right is an open space surrounded on three sides by a small temple, an agricultural bank, and the village cooperative store. The village meeting place, where the clinic is to be held, is open at the sides, but with a concrete floor and a good tiled roof. The van backs up to it, the back doors open and we all clamber out. We are greeted by Saraswathy, who is CHAD's part-time community health worker (PTCHW) in the village.

PTCHW

Saraswathy came to Sholavaram at the age of 13, when she got married. For years, she worked mainly in the forests, cutting wood, with breaks for having babies or for seasonal labor in the fields. But Saraswathy had another skill. Her mother and her mother-in-law were both traditional dais (midwives). From an early age, she went out with her mother on deliveries, and then after her marriage, she became a familiar figure in the village as her mother-in-law's assistant. So when CHAD started asking round the village for a dai, she was the obvious choice. She applied and the village selected her for training.

She spent three months at CHAD Hospital, mainly in the labour room, conducting deliveries and learning the principles of sterilization, palpation, antenatal and postnatal care, and how to log the progress of labour. She learnt to recognize when hospitalization was needed, and how to keep records. Then she spent a further month in a government hospital. She and the other trainees learned a lot on this training. 'Some of the things we used to do seem incredible now,' she says. For example – incredible though it now seems – before the CHAD training, one of the other trainee PTCHWs used to use a sickle to cut the cord when conducting deliveries.

Saraswathy is the front line of the CHAD health team at Sholavaram. She knows the village intimately: it's her job. Today, her years of caring for families and bringing babies into the world have made her a respected member of the community and a friend to many of its members. Sometimes people call her 'doctor', which she likes very much. She treats minor ailments and injuries, conducts deliveries, and joins up with the mobile health and leprosy teams when they visit the village. She chases up candidates for immunization or antenatal care, and can refer patients to CHAD Hospital if necessary. She reports births and deaths, and keeps records of all pregnancies and under-fives in the village.

Her job is called 'part-time'. In practice, she is on call all the time, and if she isn't available people complain that she's not doing her job. For CHAD PTCHWs, this may rule out the possibility of supplementing their incomes with casual work at harvest time, which is what most low-paid village workers do. Recognizing this, CHAD has a scheme for supplying cows to PTCHWS, and many of them now earn valuable extra income in this way. Nobody could call Saraswathy's life easy: but she can't imagine any other occupation that would bring her the same job satisfaction or status in the community.

Clinic day

So the clinic begins. A big crowd has already gathered: pregnant women, women with babies, restless small children, and some few men, standing a little apart. But this is a social occasion too. The clinic is on the way to the co-operative, and also to the bank. Beyond them is the CHAD balwadi, or crèche: no children today because of Pongal, but teachers Ponni and Jayalakshmi are there, and so, normally are twenty-five under-five children, being cared for while their mothers work. Ten minutes walk in the other direction is the basketry co-operative, built for CODES members by the village youth after the old one had been burnt down in an arson attack. The clinic has become the hub of community activity. People pause as they walk through and stand around, passing the time of day and checking out the village gossip.

Outside, intern Dr Ann Mary Augustine sets up a table and gets out her records. Her job is to screen everyone who comes. She takes the blood pressure of pregnant women, deals with chest complaints, skin conditions and injuries, and provides repeat prescriptions for chronic illness. A wriggly nine month old has a respiratory tract infection; Greeta the health aide is concerned about an eight-day-old baby with a low birth weight; a big man with a pear-shaped face has chronic asthma and seizures, and now he is feeling generally unwell. Two patients need referring to CHAD Hospital: a bemused looking woman with a head injury caused by falling down a well, and a boy with impetigo. Neither is willing to go, or not till later in the week, because it would mean missing out on the local Pongal festivities. At another makeshift table, a lab technician is drawing blood samples for testing in the CHAD laboratories, Greeta is working on the records that will eventually be fed in the CHAD health information figures, and Palani, the van-driver, is keeping himself busy by weighing the babies.

But now there is an interruption. At every CHAD clinic there is a health education session. Children are shushed, everyone settles down on the ground, and Priya Roseline, the CHAD staff nurse gets up to speak. This week's topic is anaemia, a common problem here, caused mainly by poor nutrition and by worm infestation. Priya is an effective, confident speaker, and the audience enjoys itself. She uses flash cards and question and answer techniques to get the message across, and a lively discussion ensues.

Meanwhile, the antenatals are queuing up outside the mobile clinic to see Dr Anandanayagi, the registrar. She examines the old patients and sits the new ones down for a chat. Most of them sign a form giving consent for screening for anaemia, hepatitis B and HIV. The back of the van is Priya's territory, doubling as an immunization clinic and a pharmacy. It is a kind of organized bedlam. One minute she is dispensing drugs through the window, the next she is giving drops and injections to infants. The drops are no problem:

but when it comes to the injections, she passes down the line and one by one the babies start to scream, until they are all at it, and on the far side of the partition they can't hear themselves speak.

Outside, the day is getting hotter. The dogs take refuge in the shade, the babies doze, and the waiting women squat down on the ground to share snacks or weak tea in thermos flasks. The CHAD team packs up and heads back to base; but for the local people, the party is still in progress.

Home delivery

It is a heavy, sunless midday in the village. The red dust of the yard seems to be everywhere, inside and outside the house. A big, black cauldron of water simmers over the wood-fire, a huge crow, even blacker, perched hopefully on its rim. Cows stamp and shift restlessly in the palm-leaf byre. A cadaverous, yellow dog sleeps, scratches itself, urinates, snaps at a few flies and sleeps again.

Shanti wanders round the yard, groaning. She stumbles back to her straw mat on the porch and kneels, kneading and dragging at the old knotted sari that hangs from the rafters. In the shade sits a group of cheerfully chatting women: Shanti's mother and grandmother; two neighbours - sometimes more; Duman Karlibai, the local Government nurse; and Saraswathy, CHAD's part-time community health worker (PTCHW) in the village. Shanti is 17, and in labour with her first child.

She gives birth at 2.56pm, on the baked-mud floor of the porch, after eight hours in labour. And it's a beautiful boy, 3.65kg on Saraswathy's portable scales. "These are not sterile conditions," says the midwife, and indeed the only sterile thing in sight is the PTCHW' s midwifery kit. This is supplied by CHAD, and contains a razor blade, some cord-tie, and a cake of soap.

The two nurses attend to Shanti (a two-inch tear needs stitching), while the other women tackle the rest of the mess. They tie the cord and cut it, wash the baby, upside-down, healthily squawking, over the stones by the wood fire, wrapping him up in white, cotton, khadi cloth. Then he and his mother are carried inside and laid on a clean straw mat on a pile of hay. Everyone is happy, and a bag of boiled sweets is handed round, to celebrate. Neighbours start coming in, carrying little gifts: bananas, some milk – or else just to look, give thanks and go away. Shanti lies there, looking as if she had given birth to the universe and found it good; and the cows munch peacefully on.

The CHAD model

At CHAD, the primary health care system is designed so that it comes to the people and addresses their needs in their own context. Health education is a crucial part of the jigsaw, conducted as it is at community level and among peers. So is socio-economic development. Through CODES, women in particular are enabled to improve family health by becoming self-reliant and economically independent [1], and the balwadi (or day-care system) provides reliable childcare facilities, so that they can work without neglecting their children. The referral system gives easy access to secondary care and laboratory facilities, and records maintained at clinics provide an on-the-spot method of collecting data.

The PTCHW is the front line of the system, supported by the health team described above. In addition, about 20% of all patients are referred to the CHAD secondary care hospital at Bagayam, a bus ride away for most villagers, while a further 3% will require the tertiary facilities at the main CMC Hospital in Vellore. In 1991, the infant mortality rate (IMR) in Kanyambadi was 50.9/1000: in 2001 it was 35.1/1000. In 1991, the maternal mortality rate was 1.6/1000, whereas in 2001 it was 0.6/1000. It is clear that CHAD's flexible, interlocking system works.

But success can bring its own problems, and one of these is the increasing use being made of the secondary hospital. On a morning when there were 380 women waiting to be seen in the antenatal clinic at CHAD Hospital, Dr Sulochana Abraham looks back at her early days at CHAD. "In 1976," she says, "we had had 8 to 10 in-patient deliveries a month. Today we have around 300. We wanted more women to deliver in hospital, and when it reached 30% of all deliveries we were happy. But then it got to around 70% and we said, 'Help!' Nowadays, in some villages, it's reached around 80% of all deliveries, and this has huge implications for service delivery. For a start, when only maybe 20% of deliveries take place at home, it changes the role of the PTCHW. But also, it places huge pressure on the secondary hospital. Our outpatients department is overcrowded, we need to update and expand our operating theatre, our lab facilities are hopelessly overstretched.". "And then," says Dr Sulo, "there is the growing number of caesarian sections we carry out. In 1976 we did none. Today, in some centers, they do C-sections for up to 50% of all patients, mostly when it's convenient for a private practitioner, or at about 5pm when the staff are about to go off for the day and they want to get it done while full back-up is still available. But you have to have a good reason for doing a C-section. WHO thinks the target for a defined population of 500,000 should be not more than about 15% of all deliveries: but I think it should be more like 7-10%, which is about what we have at CHAD."

1 See Chapter 3, on development

In order to meet these demands, the Danish government's Danmission through DMCDD, (Danish Mission Council for Development Department) is giving them a big new building, on the CHAD Hospital site, designed to house new outpatients, operating, maternity and theatre facilities. But the increased demand for hospital services has unquestionably changed the balance of the primary health programme. Today, while the core tasks remain the same, the local part-time community health worker (chosen originally for her midwifery skills) is more of a facilitator and agent of change than she was ten years ago: a role that requires different skills, different training and possibly a different kind of person.

'We're going crazy....

Dr Daisy Singh's mother died in childbirth, when Daisy was six. From that day, she says, her life has had one overriding purpose: to ensure that mothers do not die, and that children are not left motherless. There were no doctors in the family, but she succeeded in going to medical school. She has worked in a remote mission hospital in Madhya Pradesh, in a private hospital in Tanzania, in a big public hospital in Australia, and in the obstetrics department at the main CMC Hospital in Vellore. Since 1991 she has been a consultant obstetrician at CHAD. She has a strong sense of having been guided by God, and having now arrived at where she is meant to be.

As a specialist clinician, why does she want to work in a secondary hospital like CHAD? "I really want to work with families," she says. "You don't get the same interpersonal relationships in a big specialist hospital. Delivering babies is only one episode in a long story, involving family planning, child welfare, breast feeding, and seeing that families are able to function as they should. People assume that pregnancy ends with the delivery: but I sometimes think that's where it starts."

The main problem at the moment is being so frantically busy. CHAD currently has four maternity beds, and conducts over 300 deliveries a month. She would love to have more time for research: CHAD serves a reasonably defined population, and there is a wealth of material available that is not being worked on. She hardly ever gets to the villages: but then somebody has to be there to look after what's going on in the hospital.

With the increasing emphasis on hospital delivery, what does she think is the role of the PTCHW? "It's a problem," she says. "Most of the PTCHWs were chosen in the seventies and eighties because of their midwifery skills. The new challenges are to do with child abuse, domestic violence, the elderly, the increasingly obvious problems of teenagers. The PTCHWs we have really are change agents and need to be trained to deal with these newer

issues. And yet that front line person – rooted in the community and chosen by its members – is central to the philosophy of community-based health care." She has no answers at the moment. "Frankly," she says, "most of the time we're just going crazy trying to keep things going here in the hospital. But I love it," she says, "and I wouldn't be anywhere else."

Dr Kurian George is the medical officer in overall charge of CHAD Hospital. He too asks radical questions. "I have no doubt," he says, "that education and training is what we are basically here for at CHAD. Our primary aim must be to create thinking, better informed medical professionals, not just in Christian health care institutions in India but much more widely, in the North as well as the South. But we can only do that in the context of a first class health care delivery service, and a high quality programme of research. It's because we've got both those that we're so highly regarded as a training center. We've always done antenatal, care and immunization and so on. What worries me is that we are, maybe not flexible enough, these days, to respond to the new challenges. In particular, the life-style issues, like coronary heart disease, hypertension, diabetes.

CHAD has always attracted talented individuals, and very different ones, too. One of the great things about it has been that you are allowed to be different, you're given a job, trained to do it, then trusted to get on with it. My job is to manage the hospital, at a time when so much is changing, and so many priorities need to be re-thought. And we're also part of CMC. Is our position on public health issues the same as CMC's position? The easy thing (especially when we're so busy) is just to stick your head in the sand, like an ostrich, and get on with it. But I do believe that in the coming years, these questions will have to be asked."

Sheba Kennedy is the MSc sister in charge of the nurses and the nursing education program at the base hospital. She is peaceful, efficient, and very well organized. This morning, there are over 400 people in the outpatients department. "Are you going crazy?" I ask. She smiles. "We are busy, yes," she says, firmly; "but we are not too busy to have a cup of coffee."

DOTS: a public health breakthrough

Tuberculosis, in India, is the leading cause of death among adults, killing more women than all causes associated with childbirth combined, and leaving more orphans than any other infectious disease. The spread of HIV is exacerbating the problem, and in India at least 35% of all TB patients are HIV positive. Today, medication can cure virtually all TB

patients, including those with HIV, provided it is taken regularly for at least six months: but TB is often associated with poverty, unemployment and inability to cope, and many TB sufferers on traditional regimens fail to complete the course. Maybe they feel better after a while and persuade themselves they are cured, or maybe they are simply defeated by the demands of a regular regime of medication. As a result, multi-drug resistant strains are beginning to appear, and these are genuinely difficult to cure. So it is absolutely crucial to find ways of motivating those people who already have TB to stick with the treatment and finish the course. This is what DOTS (or Directly Observed Treatment, Short-course) is designed to do.

The concept is a simple one. When the patient agrees to join the program, he or she must choose a local volunteer 'provider', who may be a health worker, but is just as likely to be a teacher, or a member of the community. The task of the provider is to collect the supply of tablets at regular intervals, and (ideally at least) to place them in the patient's mouth at the appointed times. It becomes the job of the provider, not the patient, to see that the tablets are taken. This has great advantages for the patient, who doesn't have to travel long distances for treatment, is guaranteed free drugs, and is supported when tempted to give up. The method has also been used successfully in addressing leprosy and rheumatic heart disease. 'The DOTS strategy,' says a WHO description, 'represents the most important public health strategy of the decade, in terms of lives that will be saved.'

There are three distinctive things about the CMC program. The first is the way it links private and public health care delivery systems. DOTS is actually a government program, but it is largely implemented by voluntary agencies. CMC is a DOTS center, with government staff- members assisting in the DOTS clinic. In this way the DOTS program, as it is implemented here, provides a model for integrated treatment programs in the future. Its second distinctive feature is the way it integrates tertiary and primary health care, so that a patient seen in the TB clinic at CMC, if he or she opts for a DOTS regimen, will be treated according to primary health care principles, in their own environment. The third is the remarkable success rate of the program. So far there has been a cure rate, for DOTS patients, of around 80%, with only around 10% of all patient-provider teams defaulting.

Dr KR John runs the program at CHAD, where all TB patients adopt a DOTS regimen. "The beautiful thing about DOTS," he says, "is that it's a perfect example of how an effective primary health care system should work. People get very excited about it, they think it's somehow something different, and the WHO protocols make it look very formal. But in practice, DOTS is how a good primary health program functions anyway: by delivering the service as near to the patient's home as possible, and by educating the community about how to implement it for themselves. This is what we do all the time."

'Indian adolescents don't have sex, do they?'

Since the late eighties, many CMC departments have been at the forefront of India's response to HIV/AIDS. Patients with HIV were admitted at a time when other hospitals were afraid to have anything to do with them. Numbers are still, apparently, relatively low in this area (in Kaniyambadi, ante-natal clinic screening puts it at about 1%). But the expectation is that it will rapidly get worse.

Dr Jasmine Helan came to CHAD in 1994 as a postgraduate registrar. At this time, the Community Health Department had just been awarded a grant, by the Rockefeller Foundation, to do a survey of adolescent sexual behavior in communities. They were also doing a major study of reproductive tract infection (RTI), which needed a woman to run it. Jasmine had been brought up as a Tamil speaker in a rural area, she was young, and she had a real rapport with village people. She was the obvious person. "You can't imagine what it was like," she says. "I'd been brought up to know nothing. I didn't know about menarche until it happened to me; I didn't know about sex until I went to college. And now here I was hearing all these things, and trying not to look surprised or shocked. I couldn't believe it."

She was astounded by the results of the adolescent sex survey, which showed that around 48% of boys had had premarital sexual experience, and 10-15% of the girls. Mainly they were motivated by peer pressure, but also by simple curiosity. "I couldn't believe it," says Jasmine. "I thought to myself, 'Indian adolescents don't have sex, do they?' But of course they do…" One or two used condoms: but they were hard to get hold of, difficult to dispose of, and spoilt a lot of the pleasure. What's more, the department was currently working with a group of sex workers in Vellore Town. At night, their main clients were truckers and other adult men. During the day, they were mostly schoolboys (recognizable by their distinctive school uniforms), and students from the nearby polytechnic.

A major new health challenge opened before them. Adolescents were not just having sex; they were having it with commercial sex workers and paying for it. However much priority they give to health education, few primary health services communicate effectively with this group. The obvious way to tackle it was through the schools and colleges. So together with the Family Counseling Center, they began to set up and run regular health education sessions in selected local schools, focusing particularly on sexual behaviour. The level of ignorance, they found, was high. Also, the young people were not willing to discuss these matters with their regular teachers. The CHAD tutors had to ask them to write their questions down anonymously, with the promise that only the health education

team would get to read them: the danger being that a teacher who knew the child might recognize his or her handwriting. These sessions have proved hugely popular, and there is a demand from other schools for the team to go in and run them elsewhere.

Nevertheless, reproductive tract infection remains a major health challenge, particularly in a time of HIV/AIDS. User-friendly advice and treatment, the assurance of confidentiality and effective health education for young people will undoubtedly be priorities for CHAD in the years to come.

'... unless you focus on marginalised groups..'

Running a primary health program means starting from where the people are. CHAD has a limited program in Kasbah in Vellore Town. The weekly clinic is located in a government facility, and deals with morbidity generally, and particularly tuberculosis.

In the mid-nineties, CHAD was approached by the organizers of a group of commercial sex workers in a slum area called Suryakulam, and Dr JP Muliyil started to look at possibilities. With HIV becoming more common in the area, local leaders had become concerned about the high prevalence of sexually transmitted and other reproductive tract infections. This was an area of open drains and dark, low palm-leaf houses, where cleanliness and personal hygiene must be unachievable. There is little privacy in such places. The decision was taken to ask CHAD registrar Dr Shantidani Minz to start a small dispensary, to run on alternate days, with a clinic in the mornings. They dealt with general health problems, but with a particular emphasis on health promotion and reproductive health. After two years, they estimated 95% condom use among the commercial sex workers.

In the meantime, in an effort to clamp down on 'immorality', the area was being regularly raided by police, making it very difficult for people trying to live lives that were as normal as possible, and to bring up children in some degree of stability. But then there was a new collector, who was determined to rehabilitate what he regarded as the 'problem areas' of the city. So police came and smashed the houses down, and drove the sex workers out. The women scattered to other cities, or to other areas of Vellore, and the general population was left to rebuild what was left of their lives. A good thing or a bad thing? "Well", says Shanti, "they are not going to stop doing commercial sex work, are they? But at least when they were here, we were able to see that they kept reasonably healthy themselves, and avoided infecting other people. Now they could be anywhere."

Where did Shanti get this feeling for marginalized people? For three years, she says, she worked for CMAI, the Christian Medical Association of India. "I traveled around and visited a lot of work being done in India. This gave me a chance to figure out what was what. The best time I had was in Bihar. I'd never seen anything like it. But my mind was really opened by that time, and I realized that you can do a lot for marginalized groups. No, it's more than that. I realized that you couldn't be serious about community health unless you focused on marginalized groups.

Another group that is increasingly marginalized in India today is older people, with local health workers reporting that their health needs are becoming increasingly urgent. Until recently, these were met within the framework of the family, and the structures of rural life. Today, with increasing urbanization and the gradual disintegration of the extended family, old people may be increasingly isolated. A health aide recently reported the case of an old man, who had brought up six children, and was left to die alone after they had all moved away.

An account of Dr Vinod Joseph's research on the subject appears in Chapter 4. For him, the health of the elderly is a challenge that primary health programmes must face up to without delay. There is a need for day care centers for old people to go to, while their families are out at work. There is also a need for some kind of hospice care for people who are dying. The implications for the future will be discussed in the final chapter.

An interface of health care cultures

In primary health care programmes, there is an inevitable tension between the needs of the community and the needs of individuals. Modern clinical medicine is increasingly focused on curing the sick individual and developing technology to help do it. The philosophy of primary health care, on the other hand, is relatively low-technology, and is focused on the community as the context where healing takes place. This places inevitable tensions on nursing and medical staff, who have been trained in clinical approaches to medicine, and want to do the best possible thing for individual patients.

Dr Anuradha Bose is a reader in paediatrics, working four days a week at CHAD and two days at the main CMC hospital. 'I am a clinician,' she says, 'but I am happy to be here at CHAD. Working at a tertiary hospital, you think you know about a condition, because you see the lab reports and examine the patient, but all the time you are only seeing one bit of the picture. To get the true picture about children's lives you need to go out into the community. The ones who come to the hospital are different from the ones who quietly die at home.

For a start, being a part of the CHAD team has made her re-evaluate the relevance of basic, lab-based research. Take iron deficiency anemia, for instance. The eighth largest killer of children in India, this is known to be associated with poverty, poor nutrition, and poor social environment. Apart from that, virtually nothing is known about it. Patients are commonly prescribed iron tablets and asked to take three a day. Sitting in a hospital clinic, says Anu, you get exasperated when they default, as many do. But then you go to their homes and ask why they default, and the reasons are obvious. The tablets are difficult to take: they taste horrible, and three a day is more than many families can manage. Why can't we design therapies that only need to be taken once a day? In the 21 st Century, is it really impossible to produce a tablet that doesn't make you feel ill when you take it?

At CMC, there is a growing recognition of the importance of primary health experience, and you find senior registrars and DCH candidates seeking postings at CHAD as an essential part of their professional development. Nevertheless, for a clinician working in a public health situation, it can be frustrating. The patient load is huge, compared with other units. In 2002, for instance, CHAD had 182 patients with lower respiratory tract infection, compared with 500 in all the other departments of CMC put together. But there is no X-ray machine on the premises. You can send the patient to CMC, but that costs more money, and the patient is often too ill to make the journey. Of course, it is usually possible to make a working diagnosis without modern technology: but it is frustrating not to be able to confirm it.

CMC Hospital is far more than an oversized mission hospital: in its field, it is one of the world's best. It is a hub of thinking and knowledge, with people coming from all over the world to share its life. The issues the institution is grappling with are important to India and to the world. Frustrating as it can sometimes be, Anu believes that it is from this interface of health care cultures that new thinking will emerge. It is for this reason that she is glad to be here.

Health education at CHAD

At the heart of all larger Tamil Nadu villages stands a small covered stage, often colourfully draped and festooned with festive streamers. Usually it is somewhere near the main bus stop, or crossroads. But if you have trouble finding it, you often have only to listen for a moment and the amplified music leads you to it: live music on this occasion, produced by a talented group of musicians, including an inspired performer on the keyboard. Tonight, you can't miss it. The whole village is gathered here, and the music is interrupted by laughter, cheers and ribald catcalls. Buses, lorries and bullock carts jam the approaches

to the village, because the crossroads has become an auditorium, and every time a vehicle passes the whole audience has to scramble out of the way.

In the middle of the stage, cross-legged, sits a small man in a cream silk shirt and dhoti. He is draped with a luscious garland of pink and white flowers. One hand is cupped beneath an imaginary breast and the other is coyly primping his hair. He has 'become' a shyly flirtatious young girl. His 'lover'- a tall young man who can hardly keep a straight face himself - looks on, with touching adoration. The crowd roars its appreciation. Then the band strikes up, a young woman sings a song; the children, bright-eyed, sway and clap, and some of the adults sing along softly with the familiar music.

Most Indian villages today have television: but the attraction of folk drama is still universal. This drama is a love story. Boy loves girl, wants to marry. Parents delighted. But then the music changes and we cut to another scene. The adoring young man has now changed his tune: he is busy chatting up a seductively dressed woman who is clearly intended to be a commercial sex worker. What is going on? All is revealed when Ms Seduction gets out a condom and starts proclaiming its benefits. The crowd loves it. But our hero is not having any of that. No, no, no, he mimes, and he fishes in his pocket for some more money. We hear the woman's thoughts: she has three children at home, all hungry, and she owes a small fortune to her pimp, or employer. What to do? In the end, she caves in, and the two go off, intertwined with each other, their intentions obvious to everyone.

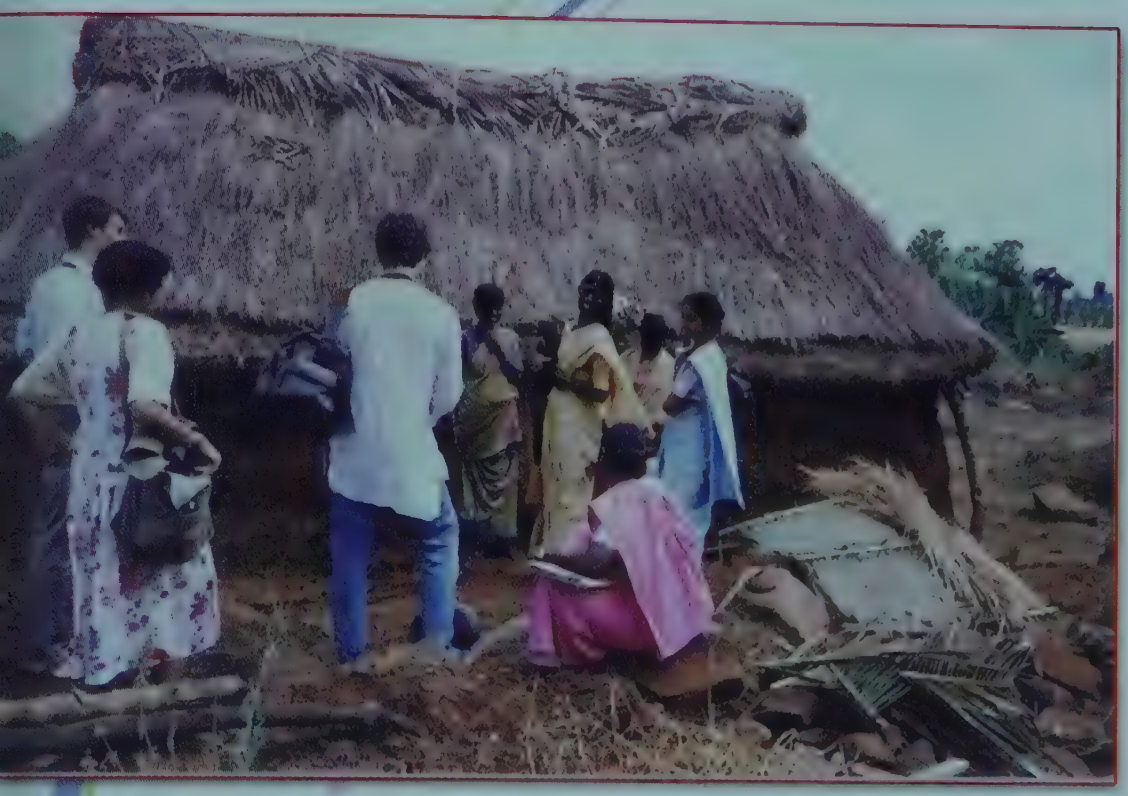
And so the sad story unfolds. The lover, of course, has contracted HIV from this or some other encounter. Neighbours suspect this, but hesitate to tell the happy families. The young couple marry, and then we cut to scenes of illness, social exclusion, loss of employment, and finally death from AIDS-related tuberculosis. The most affecting scene is the death, aged nine months, of the couple's baby, born with HIV.

Mr Maruthamuthu is head of health education at CHAD. Creative and innovative, he is a passionate believer in the effectiveness of traditional media in getting health messages across, particularly to younger people. The AIDS drama described above is one form of popular entertainment: a story or drama interspersed with songs that everybody knows. Nowadays, though, much of their dramatic work is in the form of much short skits based on popular songs, and the subject matter could equally well have been tuberculosis, leprosy or alcoholism. The CHAD health education drama team now has its own highly professional music group in the villages.

But health education is not just the task of the health education team. For every single person working in a CHAD program, health education is a major priority. There is a health education component to every piece of research and every clinic. It is no good treating a child with malnutrition without making sure the mother knows how to feed her properly in future. It is useless to start somebody on DOTS treatment for TB if they do not understand the implications of defaulting. And so on. So it is common to see health aides and PTCHWs giving flash card demonstrations to the little groups gathered around the local village clinics.

An important dimension of health education is the development of ways for local people to be involved in the solutions to problems. For an outbreak of dengue, school children were involved in getting rid of the mosquitoes that carried it. In a solar water disinfection program, local people were involved in the process itself and in assessing the results. Education in personal hygiene is an essential component of a latrine-building project. Sometimes, even, there is support from unexpected sources: one day the driver of the mobile clinic that takes the health teams announced that he was tired of sitting idle while he waited for them to finish, couldn't he learn to do health education himself?

Strictly speaking, Maruthamuthu's work comes under the heading of development, which is where his job is located. CHAD's development activities are described in the next chapter. But health education cuts right across the health and development agenda. It is a matter of empowering people to take responsibility for their own well being in their own context, and against the backdrop of their own daily lives. In this way it impacts on every part of the community's life, and does it in such a way that health issues are not boring but fun, and that the solutions are placed within the hands of the people with the problems.



Students making
a home visit

A happy student
posing
with children

Students and faculty
line up with the
children in a tribal area

Taking care of
baby sister

Pedal power gives
this young girl
independence

Looking at a new range
in the tribal areas
. . . . . miles to go

Chapter 3

CODES AND THE IMPACT OF DEVELOPMENT

Building self-reliance and leadership capabilities at local level is the most important ingredient for sustained development and progress in health.

The Alma Ata Declaration, 1978

No health without development

Today, there is no real disagreement about the importance, for good health, of a healthy lifestyle. To survive, you need food. To be healthy, you need enough of the right kind of food, plus a reasonably clean environment, and also, preferably, a purpose in life, or something you feel is worth keeping healthy for. Without these things, formal health services are little more than a patching up operation: the patient may be fine when he or she leaves the hospital or clinic, but is often going back into the very environment that caused the illness in the first place. For this reason, it now goes without saying that for primary health care to make a difference in poor, disadvantaged communities, it needs to be accompanied by the kind of socio-economic development that helps people to feed themselves and their families, and to create an environment that is not constantly undermining their efforts to stay healthy. And this can involve change – quite radical change – in the way people live.

The problem is that social change is never easy. For a start, it is easier to justify doing what you have always done than it is to justify changing things. People often feel that change is somehow immoral: as if 'the way things are' is also 'the way things ought to be'. We all know about the tyranny exercised by the statement, 'We've always done it that way'. In any society there are usually far too many people and institutions with a stake in keeping things the way they are.

In India, 40-50% still live below the poverty line. The factors that make it so hard to address that poverty are deeply (pessimists believe permanently) engrained in the fabric of society. Caste, land ownership, illiteracy, debt, exploitation of labour, the low status of women and girls, superstition, a fatalistic belief in the inevitability of suffering: all these are the enemies of health and development. It is not surprising that so many efforts at development fall by the way side. Apathy and hopelessness, it is said, are greater enemies to good health even than poverty – with which they often go hand in hand.

It all seems so obvious. If you have no money to buy food and no land on which to grow it, you must work, and be paid either with food or with the money to buy it. If you earn in a day just enough to feed your family for a day, then a day's work missed means a day when you don't eat. If for one reason or another you are unable to work at all then you don't get paid at all, and that (in a country with no social security payments) means you either go into debt, or you depend entirely on the generosity of family or neighbours for your own survival and that of your family.

This understanding of health can result in an either-or approach to the practice of community-based care. For example, some primary health programs (daunted by the challenge of engrained poverty) stick to the traditional health agenda: midwifery, mother and child health, immunization, childhood diarrhea and so on. Others believe that it's a waste of time running a health program when the health status of the community is so fatally undermined by poverty and underdevelopment, and for these the entry-point is economic empowerment and community development. CMC's RUHSA program could be said to come into this category.

In the CHAD philosophy, as its name (Community Health and Development) would suggest, the emphasis is on 'both' rather than 'either-or'. From 1957, twenty years before Alma Ata, it started encouraging agricultural and dairying projects, adult literacy, and the setting up of income generating co-operatives for women. Today, with health indicators in Kanyambadi block as good as any in India, CHAD acknowledges that its relative success in tackling these would have been impossible without the fullest possible integration of health and development.

CODES: A cornerstone

As the name implies, socio-economic and community development is a cornerstone of its vision. Early efforts centred round locally organized cooperatives, supported by CHAD extension and agriculture workers, and engaging in such activities as dairying, goat rearing and craftwork. However, it gradually became clear that a more systematic and coordinated approach was needed, and in 1978 the decision was taken to set up CODES, the Community Development Society. CODES is now an independently registered NGO. Its board is divided 50/50 between CHAD staff and members of the society, with the Head of CHAD as its non-executive President.

Most (though not all) of those who benefit from CODES are women. Women are the most vulnerable members of rural society. Agricultural work is available only when there

is rainfall, there are few other employment opportunities at the village level, and childcare responsibilities make it difficult for them to travel for work. And yet the last forty years have produced incontestable evidence that the health and welfare of the whole families improves when mothers are in a position to take some of the decisions about how family income is spent. Men do, of course, benefit from the improved level of family well being, and are involved in some of the programs: but the primary focus of CODES is the economic, social and personal empowerment of women.

Good health is not just to do with money, food, and the availability of medical services. It is also dependent on a healthy environment. The lack of adequate environmental sanitation has contributed to the high incidence of diarrhoea and worm infestation, especially in women. Without some privacy, women and young girls find personal hygiene impossible, particularly during menstruation: and yet, by 2002, only 5% of all homes in Kanyambadi had toilets. It is a current health priority at CHAD to address this problem, and also to reduce the incidence of reproductive tract infection. With the help of Danmission and the Danish International Development Agency, CODES is now embarking on a major new latrine-building program, encouraging involvement by village people and accompanied by education on the dangers of open-air defecation. Each family is asked to pay Rs1000/- towards the cost of building materials, and also to contribute to the actual construction: a venture that will, it is hoped, improve the health of whole families.

Full of bustle

Susila Suriya is a calm, warm woman with a deep commitment to her work and an equally deep modesty when it comes to talking about her own achievements. One morning, we leave CHAD and walk through the maze of dusty campus road to the CODES compound. In a big, barn-like upper room, around 40 women are at work. At one end, women are bent over sewing machines, clacking away over the little smocked children's dresses and jackets that sell so well. It is bad luck to invest in baby-clothes before the child is safely delivered, so they do a successful line in packs for babies delivered in CMC hospital. Each pack contains a tiny smock, a jacket, a cap, a cot sheet and a collection of diapers: items which mothers treasure from one baby to the next. Some of the women are learning to do machine embroidery At the far end of the workshop, women are sitting on the floor doing smocking and hand embroidery for tablecloths, handkerchiefs and women and children's clothing.

The tailoring shop is full of bustle today, because CODES is running a stall at a big international scientific conference on the College campus. It is like an Aladdin's cave, with piles of small purses and folders made of jute or sisal, a rainbow array of tablemats, packs of delicately embroidered hankies. There are wonderful bags – little backpacks, shopping bags (all different), and colourful shoulder sacks. Everything is beautifully made, immaculately stitched. These are being packed into boxes for transport to the conference venue. It's noisy and busy, with signs of purposeful productivity everywhere.

The economic benefits are indisputable. Before they got involved with CODES, these women earned around Rs20/- a week: here they can earn up to Rs400/-. CODES encourages members to save as much as possible through its thrift and credit scheme. All the women have been able to buy sewing machines for use at home, enabling them to make extra income from private orders.

The operation is generally overseen by Susila Suriya, but the person responsible for the day to day management is Gnanam: a competent, hardworking woman who travels 40 km from Arni in order to work at CODES, and then back again in the evening. Gnanam is making a little smocked pink and white cotton child's dress, immaculately finished and with tiny, beautiful stitching. She is an artist: but she is also, clearly, an excellent manager. But this main workshop is only one part of CODES CRAFT enterprise. The society, after all, was set up to give women access to work as locally as possible, and many Kanyambadi villages today have their own workshop. Originally, says Susila, it was uphill work persuading women that they could manage to work in this way. She recalls the early days, when she went from village to village, attending mathar sangams, initiating debates, persuading and encouraging and supporting. To many of the women who joined, it was unthinkable that they (who had never done anything independently before) should be capable of organising in this way, and contributing as substantially as this to the family income.

This scene of business-like activity may seem a long way from the original objective of improving women's health. And yet in some ways, the wheel has come full circle. Perhaps the most significant comment came from a founder member of CODES. "When I first joined CODES," she said, "I couldn't have taken my baby to the hospital unless it was free. But now, if the family is sick, I can pay for what they need, and for their school as well. I don't need free health care. I can hold my head up because I earn my own living."

Family Counselling Centre

The need for the Family Counselling Centre arose from the work of the health teams, who found themselves encountering more and more cases of alcoholism, family breakdown, child abuse and wife beating. The HIV/AIDS epidemic gave rise to new demands for counselling, and there was, in addition, a steep rise in the number of suicides. Family health can suffer catastrophically in such cases: and yet support for suffering families takes time. In the end, health staff found it impossible to manage their already heavy workload with a much-increased need for family support and counselling.

The Family Counselling Centre was set up under the leadership of Susila Suriya and by Mr S Maruthamuthu, CODES' Secretary. Many of the problems they encounter can seem quite trivial: it's just that if they are ignored, they can turn into major crises. The question is how to put in place the kind of safety valves that will prevent situations from reaching crisis levels. This was less of a problem in the old days, when the joint family system was still operating effectively, and village leaders had more real control over what happened. Then, it was possible to sort out problems before they got out of hand. Today, the break up of joint families and the dwindling of respect for traditional leaders have left a vacuum that is felt across the nation: the CODES family counselling program was made possible by a Government of India grant.

Visitors from overseas are sometimes startled by the extent to which counselling is tied up with development and practical help. Susila explains. "It's not much use," she says, "just to sit and listen to somebody's emotional or relationship problems, when their most urgent worry is not being able to feed their families, or having nowhere to live, or facing violence from neighbours or family members. So we often spend a lot of time trying to sort out practical problems, with housing for instance, or with getting loans or finding some kind of employment. Also, we are trying to tackle some of the root problems. In India, when a couple married, the joint family and the village community used to exercise some control over their expectations, the care of the children in times of trouble, and also what happened within the marriage. Young people are much more 'on their own' these days."

With the help of CHAD staff, therefore, FCC now runs newly married couples meetings, where couples are encouraged to discuss issues of communication and adjustment, and to anticipate the kind of problems that can occur within families: decision making, financial issues, disputes relating to parents-in-law, children, a partner's drinking and so on.

Changes in family and community life have also left adolescents with a less clear structure to their lives. FCC and CHAD set up a series of local groups for vulnerable adolescent girls who had dropped out of school: groups that were so popular that they have now started to work with boys as well. They have also accepted invitations to go into schools to talk with girl students about their problems, and have been invited to work with the District Collector's Office and the District Social Welfare Office. Is Susila busy? "Of course," she says. "But what else can we do? It's much better to help sort things out before the problem becomes a problem, and before it starts to affect the family's health."

Beyond the margins

Small farmers have a difficult time in an unregulated market. Take small turmeric growers, for instance. There are many of these in Kanyambadi. During the growing season, when there is plenty of turmeric about, they will get around Rs600/- per bag for it. If they can wait a few months before they sell, the price can rise to as much as Rs4000/-. But most of them can't wait. They are desperate for money, and they have nowhere to store the turmeric anyway. Initially, CODES helped by setting up SMASH (the Small and Marginal Agriculturalists' Storehouse). The farmer borrowed from CODES the Rs600/- he would have got for the turmeric in season, and CODES stored it until the price went up. The farmer then collected the crop, sold it for Rs4000/-, returned the money borrowed from CODES, plus a small storage fee, and kept the profit. This group is now building a 'go-down', or storage centre. Under the title of FOCUS, they also hope to set up an independent self-help association to be run on the same lines as the SHARE collective described below.

Disability, in developing countries, is an even greater challenge than it is in Europe or North America. Rehabilitation is expensive in staffing, materials and time. Where people are struggling to deal with 'acute' medical needs and cost-effective preventive care, it is rarely a priority. Imprisoned in bodies that refuse to do what other people's do, often excluded by their disability from 'normal' jobs, the disabled are among the most marginalized in society. Many would rather ignore their existence completely.

For this reason, all CODES programs try to include disabled people wherever they can: the tailoring unit, for instance, numbers five physically challenged women among its members. In addition, a number of CODES programs have been designed specifically to benefit disabled people: an initial investment that has the effect of transforming resource burners into resource earners and giving them the sense of dignity that comes from working for one's living. One example is the growing chain of STD booths on the college and hospital campuses, offering 24-hour-a- day national and international telephone facilities,

and making a big difference to students, staff and patients. Other examples include a candle-making project, selling candles through the CODES shop, and a waste disposal project on CMC campus. Other successful projects include the CODES auto service station (which employs and trains young boys), a hand-made paper unit, and a project that produces hollow concrete blocks for building houses.

Not far from the CHAD compound is Vellore Women's Prison. Women are sent here from all over Tamil Nadu, often accompanied by babies and young children, and often hundreds of kilometres from home. Concerned about the lives of these families, and the difficulty they face in managing financially and socially when they are released, Susila Suriya and her colleagues accepted an invitation to go into the prison on a regular basis and do some counselling with the women. "But really," says Susila, "that wouldn't help much, would it? It might give emotional support, but in fact, they have nothing to do, many of them have no skills, and they are just terrified of what will happen when they are released." So they started to support the tailoring workshop in the prison by supplying fabric, so that the women could learn to stitch garments and make money selling them. There are plans for CODES trainers to teach confectionery baking, and they got a laminating machine, so that the women could earn money processing ID cards. Then social workers trained a teacher to run a balwadi (nursery) in the prison. Sadly, there have been extra government security concerns recently, and the CODES people have had to stop going in for the time being. "But we will go back tomorrow if we're asked," says Susila.

Marketing, for small, local craft businesses, is often the biggest challenge they face. Many craftwork programs make items for overseas markets. CODES, however, has concentrated its efforts on meeting the needs of local markets, and as a result, that is where around 80% of its income comes from. In particular, it takes advantage of the opportunities offered by the CMC community itself, and its constant stream of visitors. On the CMC campus, there is a CODES shop, which sells craft items from the CODES projects, and from other NGOs in Tamil Nadu . Now they want to set up a tailoring outlet on the main hospital campus in Vellore Town, so that people can bring their own fabric, talk to the CODES representative in peace about what they want to order, and have it made up at the CODES workshop in Bagayam. Set up to promote economic and social development at the level of grassroots community, CODES is now making a real contribution to the facilities available both in Bagayam, where CHAD Hospital is based, and for the thousands of patients and staff who come, every day, to the hospital campus in Vellore Town.

Child of CODES

In 1991 a group of women got together and decided that they were now ready, after 15 years of training and experience with CODES, to set up and run their own business. The result was SHARE, the Self Help Association for Rural Education and Employment. While the board of CODES is divided 50/50 between community representatives and CHAD staff, SHARE has only one CHAD staff member, D Murugesan.

Otherwise, it is run entirely by its women members. Until '91, the original group were all members of CODES, some of them very longstanding ones. Here they had learned their craft, and also a great deal about management, marketing, accounting and the disciplines of running a business. Some of them had travelled around India, to craft fairs, so they had met others doing similar things and seen what sold well and what didn't.

Today, SHARE is big business, more centralised than CODES, but with 800 women working through 21 craft centres. 75% of what they make is for export, and at the moment, this is going very well. They have long-standing customers among fair-trade organizations in Europe and North America and Australia. Recently, they have received a big contract from Body Shop for palm leaf baskets, using vegetable dyes, to be used as decorative packaging.

But SHARE is more than just the palm leaf units, although that is where it began. Today it says it has 3000 members from over ninety villages, committed to supporting and training women in leadership and economic management. It is the logical development from CODES, with its women's self-help groups and development programs, its involvement in government schemes, its expanding business and its strong emphasis on self-help training. The governments of India and of Tamil Nadu are deeply committed to the self-help movement, and SHARE (like CODES) is frequently asked to provide training for government-run workshops. In addition, women have been to China, Europe, Bangladesh, Sri Lanka, either to international conferences, or in order to develop markets, meet other craftspeople, and see for themselves what is happening.

No longer a man's world

In India, traditionally, local politics is a world of men. In the early days of CODES, they used to dream about how different things might be if there were more women panchayat members, and even – impossible to imagine – a woman panchayat president. In those days it was little more than a dream. Today, no longer. With so many women gaining confidence and financial awareness, the male stronghold is beginning to crumble. At least a dozen CODES-trained women are now panchayat members, elected by their own people.

Twenty years ago, Selvi Arul was a school drop-out with no particular future prospects. Susila Suriya first came into contact with Selvi when she took part in a village holiday camp for girls, where she noticed her because she starred in the acting, and in the public speaking competition. She persuaded Selvi to join the local mat-weaving co-operative, and in due course she was selected by the village for training at CHAD. For ten years Selvi went out to the villages, day after day, in her pink health aide's sari. But then someone suggested she stand for election to the panchayat. To her astonishment and delight, she was elected. Today, she is president of the Pennathur panchayat: the first woman ever to hold this position.

The daughter of a day labourer, Rani Mani came from a family with eight brothers and sisters. She longed to study, but as a girl, school was a luxury the family could not afford. Aged fourteen, she was married to somebody she didn't know, and soon she was pregnant with her first child. She felt her life was over and her dreams dead. Then she heard about the palm leaf basketry cooperative in the village, and that was how she came to CODES. She has never really looked back. She became a leading light in CODES. She began to visit craft fairs in other parts of Indian sub-continent, and she won an award from the Design Federation of South India. She learned to read and write, and to speak a little English. She was the first president of SHARE, and today she is the first woman president of the panchayat of Edyansathu.

Both women talk of their days in CODES as 'a base part of my development'. Some people think of CODES as 'just another basketry or tailoring initiative'. But in reality it's far, far more than that. For Selvi and Rani, it's where they learned what it means to be part of a community, and also what it means to be somebody in your own right. It's where they developed as individuals and as women. It's where they re-thought old assumptions about men's and women's roles in the family. It's where they first started to ask those crucial questions about how things should be run, and how government might look if those involved were genuinely working for the people. Yes the skill training and the income generation were important: you can't get anywhere without these. But the real breakthrough comes with the sense of empowerment, and the realisation that you have something unique to contribute to the world.

A village balwadi
(Nursery School)

Regular exercise keeps the
elderly fit

Taking care of the
elderly

Fun together
after exercise
International Award for
Young People

Women Masons
constructing a toilet
in the village

Training in welding
enables this woman
to be independent

Embroidery brings
meaning to
women's lives

Chapter 4

RESEARCH WITH A HUMAN FACE

Nobody at CHAD can get away with saying
'do it because I say so',
or 'we've always done it that way'.
Dr JP Muliyil

Research in context

What is research, and who does it? The stereotypical image of the medical researcher is the scientist, highly specialized, who wears a white coat and works in a laboratory or tertiary hospital. His or her work is probably incomprehensible to anyone who doesn't have a medical background, and maybe also to some who do.

At CHAD, this has never been true. Here, research is to do with real problems, identified by real people, who need solutions they can manage themselves in their own homes, communities and workplaces. In August 2001, there was a major outbreak of fever, in a village not 10 km from the base hospital in Bagayam. The first the CHAD people knew about it was when a young man walked into the hospital, bleeding from the nose. They examined him and did a few tests. "Your platelets are down," they said. "How long have you been like this?"

"Around two weeks," replied the patient. "But it's not just me, the whole village is ill now." And when epidemiologists Vinohar Balraj and JP Muliyil went with some students to investigate, they found that this was true. More than one third of the village was sick with dengue fever, a mosquito-borne disease that is transmitted in much the same way as malaria.

Of course the first task was to treat the sick people. But at least as important was to look for the mosquitoes that were transmitting the disease. It had rained recently, and what they discovered was that there were little collections of stagnant water all over the village, in small clay pots, coconut shells and other receptacles, and these had become the breeding ground for the dengue-carrying mosquitoes. So they went into the local schools, explained to the children (those who were not already sick, at least) what was going on, and taught them to go around the village, looking for these pots and upturning them. By getting rid of the water and stopping the receptacles from filling up if it rained again, they removed the

mosquitoes' breeding ground. Then they reported the epidemic to the government health department, who sent a man to spray the mosquito sites with a chemical 'fog', and this got rid of the mosquitoes that were already there.

This story includes the treatment of people who are already sick: but in addition it includes research training, scientific enquiry, health education, community participation, and collaboration between government and an NGO. It is a perfect example of what community-based health research can achieve. Contrast that with the private doctor who had been treating some of the villagers. He had come to visit, charged a big fee, and gone home without making any attempt to identify the source of the outbreak.

Simple Solutions

At CHAD, research has always been part of the curriculum. As part of the community orientation program at the end of the first year, students learn to collect data, organize it and analyze it. In the second clinical year, they conduct a small independent study of their own design. Every intern has to conduct and present a piece of applied, community based research work, and comment on the methodologies used. Investigations undertaken by CHAD interns include:

- A study of respiratory problems in Vellore traffic policemen. (There were many, but in addition, there were high levels of hypertension and diabetes.)

- A study of behavior change among primary school children, resulting from education on the use of bicycle helmets. (They loved them, some of them wore them in bed even: but the intern finished the placement before they managed to find out the level of changed behavior after six months.)

- A study of financial, medical and social status of elderly people in one area.

Ramanayakanpalayam is a slum area of Vellore Town, accessible via an alleyway leading over a patch of scrub and between ramshackle huts. These are dark, claustrophobic caves where huddles of women are crouching over their work: which in this case is making up cardboard matchboxes. For a basketful of these – a couple of hours' work - they are paid Rs4/-, which is around .08 of a dollar in US money. Bedraggled children hang listlessly around: not hostile, not even curious, but with a kind of apathetic fatalism. On one side of the alleyway is a filthy ditch, where women are washing clothes. Washing? If they go in dirty, it is hard to see how they can possibly emerge any cleaner. This used to be an area

well known for the number of commercial sex workers, until the local collector decided to conduct a 'purge on immorality', and they scattered to other places.

When Dr Anuradha Rose was planning her MD thesis, she identified childhood diarrhea as a major problem in this area. How could they develop simple, inexpensive, non-technical ways of sterilizing water? She had heard interesting things from visiting faculty from Sweden. You do not need to bring water to boiling point in order to remove most of the organisms that make people sick, they had said. In Kenya and Lebanon, they had been conducting experiments in solar sterilization that seemed to have worked. She talked to the local people and selected a defined population of people who were prepared to help. Then she went to a stall in the bazaar that sells second, third and fourth-hand stuff that can be used again, and she bought a collection of old plastic mineral-water bottles, which she sterilized. Every day, the women filled the bottles with water, stood them on a flat roof in the sun, and left them there for at least 3 days. In six months, the incidence of childhood diarrhea had fallen by 30%.

In the past 10 years, says Vinohar Balraj, staff working in tertiary care have shown more and more interest in getting out into the community. This is partly as a result of the epidemiology training courses described in Chapter 1, which all senior faculty at CMC have attended at one time or another. But also, an experience of applied community-based research may open doors, these days, on the national and international stage. It is no longer enough to check out whether solutions work out in the laboratory, or on the hospital ward. What is often needed is to develop low-cost, easy-to-manage solutions – like the ones described in this chapter - that can be undertaken at the level of community, and have the potential to improve its health.

JP Muliyil comments on his own long experience as an epidemiologist. "For students and interns," he says, "the emphasis on research constitutes an absolutely crucial element in their training. It ensures that they learn to think independently about clinical decisions. They know how to go about checking things out for themselves. And nobody, now, can get away with saying 'do it because I say so', or 'we've always done it that way'".

Qualitative research

Most of us, in our time, have had the following experience. You are asked to fill in a questionnaire. You're interested in the subject. You may even feel strongly about the issues. But you find that the questions are all, somehow, missing the point. Selecting from the multi-choice options available, you feel like answering 'none of these'.

Community based research is particularly prone to this syndrome. The questionnaire may be drawn up by professionals working a hospital or laboratory situation, and designed in such a way as to provide answers to questions they want answered. But for people on the ground, these may not be the issues at all. As a result, however coherent your conclusions appear, they may not be an effective basis for health education or for service planning. For example, in one community you may want to address the problem of childhood diarrhea, which you believe is caused by an unclean water supply. What you may not realize is that the community is starting from a quite different place. From their perspective the water is clean, and childhood diarrhea is caused by supernatural influences such as being touched by the shadow of a flying bird. Adult diarrhea, on the other hand, is caused by overheating the body.

Clearly such beliefs have major implications for program planning, which assumes people accept the association between diarrhea and water supply. If supernatural factors are to blame for it, the treatment is to take the child to the priest or local healer to have the spell cast out. If overheating is the cause, people may believe that the answer is a cold bath. The questionnaire needs to be constructed in a way that is designed to uncover these crucial understandings. What is required, therefore, is a brief preliminary study, designed to provide the researcher with clues about what questions he or she should be asking.

The focus group is a useful tool for doing this. First a group of key informants are invited to participate. These should be – for example – the policeman, the dhobi, the teacher, the dai: people who know what is going on, and who do a lot of gossiping. The group is then invited to discuss a series of statements about the topic under discussion. The discussion is recorded, and annotated to indicate body language that might affect the meaning of what is being said; then the findings are analyzed and used in the construction of the quantitative survey.

Mr Ranjith Kumar is a social scientist, working in the development program. He recalls the time when CHAD was involved in a WHO-sponsored study on the socio-economic effects of filariasis. When they tried to draw up the questionnaire, they realized that they had very little real idea of how the community itself perceived the problem. So they set up focus groups to help them see where the quantitative study should be pitched. The results were illuminating. In Tamil, the phrase for the condition is 'yanai kal', or elephant leg. The leg swelling was what defined it. But filariasis also involves scrotal swelling, and in some places (mainly in Africa) swelling of the upper arms. The villagers did not perceive these additional symptoms as part of the same condition, even if they occurred at the same time. Scrotal swelling was connected, they thought, with injuries caused by riding a bicycle or

with playing kabadi. To treat it, they would take a cold bath, tie up the scrotum with string and cover it with a special paste. They rejected the idea that there was any connection with 'elephant leg'. Armed with this information, the research team was able to draw up a questionnaire that had a real hope of identifying the issues as people saw them, and of providing a basis for a way forward in terms of service implementation.

Making sure the system works

Public health systems require effective information systems. Without accurate data, you can't decide where the gaps are in your immunization program, whether your water chlorination program is working and so on. In the past twenty years, CHAD's information system has gone a long way towards improving the quality of care. Since 1986, the perinatal mortality in the CHAD area has come down from over 60/1000 to less than 30/1000. This data is of incalculable use within the CMC system, and also more widely. For the Danish government's development agency DANIDA, CHAD recently undertook a baseline survey on reproductive tract infections (RTI) in two districts of Tamil Nadu, and also a baseline survey on how primary health centers work.

At district level, NADHI (the North Arcot District Health Information Service) was set up to help the government health services to see how well their services were operating. Dr Vinohar Balraj coordinates this program. "This can lead to problems," he says. "When we first started in 1984, the district health system wasn't reporting. NADHI studies showed clusters of polio in places where the district's data was showing 100% immunization levels. Which of course is impossible. At first the government didn't believe us, but then we proved to them that it was true, and of course they were highly embarrassed. So we investigated and found out what was going wrong, and they were able to put it right."

"There's a major policy role for NGOs in India," he says. "Fortunately government encourages it. They want to address issues of low efficiency levels and a poor work ethic among their own personnel, but they see the difficulty of asking those very staff to monitor their own work. As a result, many government organizations use NGOs to evaluate their work. For example, we were recently invited to review the Vellore district's RTI program. This has sometimes led to conflict with government medical officers: but we are not policemen, we are just reporting facts, and in general our relations with government are very good. Now they really value the monthly health figures we produce."

The NADHI system is also used by others, including not just CMC faculty but also organizations like the Johns Hopkins School of Public Health and the World Health

Organization. It is also able to respond to more service orientated requests. For example, there was a request from paediatricians and haematologists for surveillance of children with malignancies and leukaemia in people of all ages in Vellore District, using NADHI system. If higher levels than expected were found, this would indicate the need for further research have implications for further research (why was this happening?) and also for service (what should we do to help?).

"We've come a long way at CHAD since the early 'eighties," says Dr Vinohar. "We used to be a very service oriented department, people were supposed to learn by participating in the health program. In those days we got complaints from postgraduates that there was no time set aside for seminars and formal teaching. The change began in 1985, when the Ford Foundation gave us money to start the Epidemiological Resource Center. Among other things, this gave us the chance to travel and study abroad and see how other people were doing it. Since then, our research capacity has really taken off. Now we're helping people from the rest of India and from abroad to develop their research agendas and acquire new methodologies. The Copenhagen group, for instance. We have senior people from all over the world here for four to five weeks. The massive amount of experience and the variety of perspectives that exist within the group make it so exciting. For instance, one year we had the policy maker on medical purchasing for the whole of Uganda. The visitors learned a lot, certainly: but I sometimes wonder if we didn't learn more."

A curtain raiser

The health care of women and families has always been a health care priority at CHAD. Women do not always have the same priority when it comes to setting research priorities. Two major recent studies have addressed issues that are of massive importance to women in India: unsafe abortion and reproductive tract infection.

Although India has relatively liberal policies on family planning and abortion, it is known that many women opt for 'backstreet' abortions rather than seek help through the statutory services. It is also known that many women use abortion as a way of limiting families and spacingchildren. The CHAD study set out to explore reasons for this, and to set out the challenges it presents for family planning services [2]. In the study population, they found a high prevalence of induced abortion, with unqualified practitioners performing 65% of terminations. When asked why, women said that they didn't approach the CHAD

2 Varkey, P et al, The Reality of Unsafe Abortion in a Rural Community in South India, in Reproductive Health Matters, Vol 8, No 16, November 2000

program because they believed the doctors there would try to persuade them to continue with the pregnancy. Nor did they want to approach the government health services, mainly because abortion advice was not available at the local primary health centers. If they went to the higher level centers, further from home, they were made to feel unwelcome or else forced to accept permanent or temporary methods of contraception. This situation, say the CHAD team, is a 'curtain raiser', exposing the ambiguity of the status of abortion in India, the slowness in the introduction of new, safer methods of termination, and the inadequacy of the legal services provided.

The RTI and STI (Sexually Transmitted Infection) study reflects a further sensitive area of women's experience: one that is becoming increasingly urgent because of the heightened risk of HIV infection that exists in women with RTI or STI. One study of young people carried out by the Community Health Department, in 13 villages in Kaniambadi block, showed that 59% of young married women (16-22 years) had one or more gynecological problem. 48 had RTIs and 18% one or more STI. Untreated, these can result in illness, infertility, and even death. This was a huge and important study, involving government and private services, plus the full range of health information and data services described above. The study is described by Dr Sulochona Abraham, who has been responsible for building up the women's health services. "With the incidence of HIV on the increase in India, especially among young people, it is imperative to learn how to diagnose and treat RTIs and STIs. Community studies are particularly important. When you're treating women, it's essential to consider their cultural practices, their lifestyles and their difficulties in approaching physicians. Without knowing all that, we can't design interventions or be sure that our approaches will be accepted."

New needs for older people

Being old is not easy in any culture. In India, until very recently, care of the elderly has been taken for granted as a feature of family life. Today, things are changing. With better health care, people are living longer. Extended families are fragmenting, moving to towns. Traditional care systems are breaking down. Making money and doing well for your children increasingly takes precedence over caring for infirm or dependent older relatives.

Dr Vinod Joseph became interested in the issue when local health workers observed that the support of elderly people and their carers was becoming a growing part of their workload. With a group of students, he decided to do a study of attitudes in one particular Kanyambadi village. What problems do the elderly face? What do they want? What would help people to care for them more effectively?

The team was surprised by the degree of consensus. The old people felt that times had changed. They did not receive the kind of respect their parents had. They were not looked after as they had expected to be. And yet, asked whether they would prefer to live in a retirement home or something similar, 95% of all people interviewed (carers as well as the elderly people) said they would not want that. 'It is against our culture,' they said. What would help, though, would be to have somewhere to go to during the day, where they could see other people, and also have somebody on hand to help if necessary. Knowing that an aged mother or uncle was being properly looked after would also enable working people to go out and earn money without worrying about what was going on at home. So the team had a discussion with one of the village leaders, who said yes, there was a building available which could be used for this purpose, and they would go ahead and see what could be done.

Similarly, the great majority of those who were interviewed said they did not want to die in hospital, among strangers. They wanted to die at home, with the family around them. Hospital is where you go when you want somebody to make you well again: that is what you pay for. People get very upset about spending a lot of money when the patient is dying anyway. On this evidence, what is really needed is a service that supports, trains and resources families who are caring for terminally ill people at home.

To Vinod Joseph, this is a new challenge, but also one that no primary health care service can ignore. They are starting from scratch, and there is a long way to go: but his dream, he says, is to use the CHAD system to develop a flexible and comprehensive home-based palliative care program that genuinely meets the needs of the local population.

All of which demonstrates the integral part that research plays in the work of CHAD, and of the Community Health Department generally.

Chapter 5

RESPONDING TO CONTEXT

'The kingdom of heaven is like yeast'
Matthew 13: 33

In assessing any school of community health, the acid test is not what happens inside it, but how successfully it equips its alumni or others to go out and work effectively in the wider national, region and international context. Many of the nurses, medical students, interns and registrars who have passed through CHAD have made a notable impact in the fields where they have gone on to work: in mission hospitals, in other medical schools, in community health programmes, and in NGO, government and international organizations. The next two chapters introduce ten of them.

The first five appear in this chapter. In Geneva, Manoj Kurian is working with the World Council of Churches. In Bangalore, Glory Alexander has left a secure position at the Baptist Hospital to set up an HIV/AIDS program for women and children. Also in Bangalore, Arvind Kasthuri is an Associate Professor of Community Health at St John's Medical College. Closer to Vellore, Gift Norman and Sushil John returned from overseas to work in the Community Health Department of the Schieffelin Leprosy Research and Training Centre at Karigiri.

The next chapter concerns a little group of recent graduates who have chosen to go and work in Orissa, one of the poorest and most backward states in India. Ravi D'Souza is working with the Orissa government. AV Ramani works with UNICEF, and Reuben Samuel with UNDP. Hundreds of kilometres away, up in the hills, Mercy Oommen is Principal of the School of Nursing at Bissam Cuttack Christian Hospital, while Johnny Oommen is developing the Department of Community Health.

Vision as mission

Geneva, Switzerland. Look towards India, and there on the horizon the sun blazes from behind the snow-capped summit of Mont Blanc. Outside the office window, cherry trees groan with blossom. Below, through the trees, the lake glistens in the spring sunshine: as does the gleaming array of cars in the Council's car park. We are in the office of Dr Manoj Kurian, former intern and registrer at CHAD, now Programme Executive of the Health and Healing Mission Team at the World Council of Churches.

It is a complex job. As health care challenges change, so does ecumenical thinking, and so also do the priorities of member churches of WCC. Manoj's role could easily become a purely reactive one, the task being to juggle these (often-conflicting) priorities so that they make some kind of programmatic sense. But it has never been like that. The Christian Medical Commission, which was the forerunner of the present health team, played a prophetic role in the story of Christian health care in the second half of the twentieth century. Today, the health team's priorities include HIV/AIDS, support for co-ordinating structures such as the Christian health associations, and the task of bringing the health journal CONTACT into the electronic age.

The style of work has changed too. The 'real work', says Manoj, is what takes place regionally, nationally or locally. Rather than running programmes as such, the name of the game is now networking, facilitating, inspiring, enabling, and the mobilisation of resources. He talks with enthusiasm of WCC's Africa AIDS Initiative, designed to promote co-ordination in community activity and theological reflection among Christian churches; of plans for resource material to combat AIDS-related stigmatisation; and of a series of regional consultations set up to encourage Christian health professionals to revisit the aims of Alma Ata and explore their relevance today.

Recent years have also seen major movements in Christian understandings of health and healing, and of the healing mission of the church: understandings which were already implicit in the pilosophy of primary health care, but are now at the very heart of the ecumenical theological agenda. Healing is no longer just the task of health professionals. Churches themselves must become agents of healing, contributing to whole persons, healed relationships and reconciled communities. It is all a far cry from the day when a young, idealistic intern arrived at CHAD, and started work among the poverty and the rutted roads and the endemic sicknesses of rural South India.

And yet Manoj claims that his time at CHAD was one of the most formative of his life, the one that – more than anything – gives him the right to do the job he is doing now. There, he learnt a huge amount about the hands-on care of ordinary people in their own contexts. 'At last,' he says, 'I saw things being done that I had only learned about in theory before.' It wasn't that the CHAD 'model' provided a one-size-fits-all solution: no model does that. It was more that he suddenly saw the potential of working for communities within the context of parallel secondary and tertiary systems: a discovery that proved crucial to his development in public health.

'CHAD was like arriving home,' he says. 'We were a family. To a large extent, we were left to find things out for ourselves: far more than they do today. And yet the teaching was inspiring.' He particularly remembers 'Uncle' standing there at 7.30 every day, in his white shirt and white pants, saying good morning to the staff as they arrived. 'We had huge disagreements,' he says. 'In Eastern cultures this is really a unique situation. I was brought up to think parents and teachers were next to God. But so long as you spoke for the poor, we could say anything we liked. So at CHAD I learned to question things. But I also learned that you have to believe in something. A commitment to community health care was more important than anything.'

Manoj would have loved to stay on at CMC, and if he had done so his life would have turned out very differently. But then his wife gained admission at Miraj Medical College, and he went to work for a small NGO locally. 'You have no idea,' he says, 'of the respect that came from having trained at Vellore.' After some years in community based health care, he was called by the then General Secretary of the Christian Medical Association of India (CMAI) to come and work at a national, co-ordinating level in its community health department in Delhi.

Now, working in Europe at international level, he looks back. 'My experience at CHAD,' he says, 'is central to the way I do this job. What we learned there wasn't theoretical; it was needs based, and it was geared to practical action. But we also learned to analyse, and to develop responses that fitted a variety of realities. It taught us to climb into other people's shoes and walk around in them. It taught us the absolute importance of working as a team. And that's really what my job is about today. The problem is that if you're going to keep your feet on the ground, you do need regular re-exposure to that formative experience. The longer you go on working in this kind of environment (he means Geneva), the further you get from people's real needs, and the more difficult it is to see the grassroots implications of what you are doing. Today my job is networking, marketing ideas, linking people, enthusing them. I could so easily lose the vision. But when Gandhiji had to make a decision, he used to conjure up a particular person in his mind, usually a poor person, and ask, "how far is this going to benefit him or her". Well that's what I try to do here.'

Would he like to stay in Europe? No, he says. This is not the reality of his people, and he doesn't want his children to grow up 'trapped in a Disneyland phenomenon' in a wealthy suburb in a wealthy city. He wants to be somewhere where they can acquire the value systems of their own people. But Manoj was born in Malaysia, although his family live in India. In order to work there, he needs permanent right of residence and a 'certificate of Indian origin'. It is very difficult.

Does the church have distinctive things to offer in terms of health care? Absolutely, he says. The longer he does this job, the more convinced he is. Healing was central to the mission of Jesus. Indeed Muslims see Jesus as primarily a healer. This doesn't mean Christians need to rush about starting hospitals. What it does mean is that we have to make a real effort to unpack the healing potential of the Christian message. Churches have always seen healing as a part of their mission. In some parts of Africa, over half of all health care institutions are owned, at some level, by the churches. There are parts of the Democratic Republic of Congo, for instance, where the church is the only provider of health care.

Over much of the world, Christian churches form the most extensive organised network in civil society. They meet regularly, and they have local, national and international infrastructures that make it possible for them to advocate extensively on health care priorities. HIV/AIDS, for instance. Worldwide, the Catholic Church alone is responsible for 26% of all care for people with HIV/AIDS, their families and survivors. 'But then,' says Manoj, 'they and other churches often undermine prevention efforts by condoning denial, silence, and the stigmatisation of the very people they seek to help. What are the congregations doing about this? Praying? Visiting? Supporting? With this massive voluntary workforce, the potential is huge. But if you really want people to change, then top-down messages are no good at all. I know this because I learned it well, and from brilliant teachers. Vidy dhanum – sarva dhanal pradhanum goes the Sanskrit proverb: Knowledge is the greatest wealth. Vidya daana, sarva daana says another: Give knowledge and you have given everything. I base what I do here,' says Manoj, 'on the principles of public health that I learned at CHAD. I may not work at community level any more, and maybe I never will: but it's only because I've been formed by that experience that I have a right to do this job at all.'

What a man should be…

During those formative years, one of Manoj's fellow-registrars was Dr Arvind Kasthuri, now Associate Professor in the Department of Community Health St John's Medical College, Bangalore. People sometimes speak of St John's as 'the Catholic sister college to CMC Vellore', set up in the 1960s to provide training, resource development and referral services for India's extensive network of Catholic mission hospitals.

Here, the community health programme is quite different from CMC's. Unlike CHAD, there is no base hospital: the Department is on the St John's campus, and field experience is gained at a rural clinic some 30km away. It is here that post-graduates spend 6 months of their training. This has the disadvantage that the teaching is partially divorced from the

fieldwork. Instead of the hands-on situations that are possible at CHAD, much of the training of students has to be done in classroom situations. But there are also advantages. Without the massive burden of looking after the base hospital, the department is able to target many of its energies into training activities. For example, reproductive and child health (RCH) is a current priority for the Indian government. With government support, therefore, Arvind is working on a project in which they identify 20 NGOs (2 or 3 in each district), and train and support them in raising the awareness of communities on the issues around RCH, and in organizing appropriate responses. He is also in the early stages of developing a training programme to respond to the growing problem of the health of elderly people.

Like Manoj, Arvind was not a CMC graduate. He went to CHAD as a registrar, and the three years that followed were, he says, 'brilliant'. He and his two fellow registrars became firm friends. First and foremost, they were desperately busy. They, along with the other registrars, basically 'ran' CHAD Hospital, on the day-to-day level. They learned the basics of MCH (mother and child health) so thoroughly that there is no way any of them would ever forget. They learned to be what Arvind calls 'competent generalists'. They learned what it means to conduct clinics and do health education at village level. In doing this they also learned the leadership skills that are needed if you are to build a team into a working unit that gets things done.

"I remember nothing but happiness from that time," he says. "We really had a ball. We started early, and we worked hard during the day. What I mainly remember is this combination of extremely hard work, and all the fun and laughter we had in addition." The strange thing is that he never considered staying on. When the three and a half years were up, he applied for a post, teaching community health at St John's and was accepted.

Does he miss the clinical work? "Yes," he says. "But at least I have the CHAD experiences to draw on. Most of my students are going to work in mission hospitals, which for Catholics means they are destined to work mainly in under-served areas. So in my teaching, to bring that context alive, I tell stories. And when I tell these stories, what I see in my mind's eye is someone or some situation I met when I was at CHAD."

"There were three things I got from CHAD," he says, "and I can't overemphasize the importance of any of them." First, the science. Epidemiology is one of the pillars of community health, and at Vellore it is just extraordinarily well taught. "JP made me love epidemiology," he says. "I shall never forget those lectures, or the way it was just part of

the life of the place. That experience is integral to the way I do my job here." The second is the confidence he got from the practical, hands-on day-to-day basic medical practice. And the third is the ethos of hard work and self-discipline: getting there on time, doing a job properly, taking responsibility for your own standards, working in multi-disciplinary teams.

Arvind is not a Christian, but he does think that Christian thinking makes it relatively easy for Christians to identify with the principles of community health. By asking his followers to help people, Jesus gave them an underlying ideology that makes it easy for them to identify with a service role, and which stops them thinking that health care is just a commodity to be handed out. "I am a practical man," he says, "and my priority is normally to ask what needs to be done at the moment, rather than engage in long discussions about human rights and long-term visions of the future and so on. That's not to say that I didn't gain immensely from being part of an environment where people discussed those things. But I think I was influenced more by what people were than what they said. At Vellore," he says, "I found I was rethinking some of my own values. I realized that you can't always judge from appearances, and sometimes the simplest folk are the most accomplished. Some of the people you meet, what they stand for, what they do: it makes you look again at your ideals of what a man should be…."

Breaking the silence

Dr Glory Alexander, formerly Pushpalatha, decided to be a doctor when she was eight. She didn't want to go to CMC: but after going through the interview process, she realised she didn't want to go anywhere else. Now, decades later, she describes Vellore as her second home, and the 'family' of CMC her second family.

After Glory qualified, she went into internal medicine, and ended up as a consultant at Bangalore Baptist Hospital. But in the mid-nineties, she found herself getting restless. For twenty years she had been doing much the same thing. It was fine, and she liked the work. But did she really want to go on like this for the next 15 years? She had always been interested in the challenges presented by the HIV/AIDS epidemic. And then, one day, at short notice, she was asked to go and talk about AIDS to a group of children at a summer camp. 250 of them. She went, and she spoke for nearly an hour. There was dead silence throughout. She asked for questions, hoping for many. There were none. And then one of the organizers said, 'I think they are embarrassed to speak of these things aloud. Why don't you ask them to write their questions down anonymously?' Within minutes, 31 little notes were placed on her table.

Shocked by the contrast between the apparent denial and the real interest, Glory realized that she had found the issue she really wanted to work on for the rest of her career. 'There is so much silence in HIV/ AIDS,' she says. In 1998, after two years of soul-searching and prayer, with nothing to go to, but with 100% support from her husband, she resigned her prestigious job and started on the road that would ultimately lead to the establishment of the ASHA Foundation. Today, after five years, she is director of an organization employing 26 people.

She would really like to see HIV/AIDS integrated, like TB, into the traditional health agenda. But as the epidemic grows, isolation and discrimination seem, if anything, to be increasing. All ASHA's work is designed to provide a continuum of care in HIV/AIDS from awareness, through care to rehabilitation and to encourage the mainstreaming of HIV/AIDS within the work of government, Christian organizations and secular NGOs.

Today, ASHA's programme has four pillars: awareness, care, self-help and sexual education. With the support of the Karnataka State AIDS Project, they run an AIDS help line, in Kanada [3] and English, which gets from 140 to 150 calls a day. They have a free HIV/AIDS clinic where they care for about 350 persons and their families, and also a voluntary counselling and testing centre .The prevention of mother to child transmission (PMTCT) is a major priority. They are able to provide medication for this, and are working to integrate it into the activity of three local hospitals by the provision of counsellors, and by providing training in PMTCT for doctors (part of which takes place at CMC Vellore).

The beauty of the ASHA programme is the careful way in which it is targeted. The government health sector, says Glory, is pretty well served. In medical terms, therefore, ASHA has tended to focus their training and educational activities on mission hospitals and Christian schools, both Catholic and Protestant. "You need to be an insider," she says, "when you're talking about a subject that is so heavily associated with the ethical and cultural life of a particular community." ASHA's education co-ordinator, Joyce Davis, has organized training in HIV/ AIDS awareness and life skills education for over 450 schoolteachers in Bangalore. Their target is to train around 1000 teachers, and to implement the sexual education curriculum in 120 schools in the state.

In relation to community issues, ASHA has focused particularly on women and children. With a mixture of anger and compassion, Glory speaks about the plight of women who have been infected by husbands, who have lost children to HIV and been thrown out by families. ASHA Foundation cares for several destitute young widows who have lost their

3 The language spoken in the state of Karnataka

husbands to AIDS. It also runs self-help groups for women. Recognizing that the most pressing problems facing rejected people are often economic ones, these groups focus strongly on income generation, making paper goods, candles and so on. Understanding 3 The language spoken in the state of Karnataka the importance of this work, and also the need to raise awareness at the level of community, ASHA also works in ten slum areas of Bangalore, with groups of anganwadi workers (women who are employed by government to do health education in the slums). They don't focus purely on HIV/AIDS, they talk about reproductive health and sexual health generally, and the importance of early diagnosis of HIV infection.

Strictly speaking, Glory is not a CHAD product. Her time in Vellore coincided rather with CHAD's predecessor, the base clinic in Bagayam set up by Dr.Benjamin in 1958. To what extent did her experiences at CMC contribute to her development into the person she is now? "Oh massively," she answers. "That was where I learned the value of commitment and of honesty, of doing things thoroughly. Also, you find that as a Vellore alumna you have links everywhere, and that's incredibly helpful. Of course I did clinical medicine, which is very individually based. I never really thought about doing community health. But the fact remained that the way I was taught and practiced clinical medicine was very community orientated. I don't know what it's like today, but in those days an awareness of the community dimensions of health care ran all the way through our training. Which meant that when I left Bangalore Baptist to start ASHA, I found that I was able to learn how to do it as I went along.

"But apart from that, what CMC gives you is this combination of work culture and mission culture, and you don't get that in many places. Wherever you are led in your life, that combination will stand you in good stead. It also gives you confidence, and a network of friends. But one thing I never knew till I did this. I find I love teaching, and by God's grace I have a flair for it. And teaching is not just giving out. The other thing I never experienced till now is the way patients have affected me personally. When our first PMTCT baby was born HIV negative, but then died of diarrhoea because we encouraged bottle-feeding, for example. Nowadays, I am busier and more deeply challenged than at any time in my life. But I am also happier and more fulfilled."

The interview finished at this point because the community team arrived back from the afternoon's training session with the anganwadis, and the room was suddenly full of flipcharts and boxes and talk and laughter and stories about what happened and who did what to whom and discussion about what was wrong with the van. It is a far cry from a clinical department in a high-powered tertiary hospital: but I can see why Glory Alexander loves it.

Watch this space

Karigiri is about 15 kms. from the centre of Vellore: a flat, rocky area that straddles the main railway line. If the name is familiar, then that's because it is the home of one of the world's best-known leprosy hospitals, the Schieffelin Leprosy Research and Training Centre. Karigiri was set up by CMC at a time when townspeople objected to the admission of people with leprosy into the main CMC Hospital, when the disease was treated with fear, and when people who had it were isolated and shunned. But Karigiri has long been independent of CMC, and today, with new medications and a greater understanding of leprosy, much of the stigma is gone, and most people with the disease can be cared for within their own communities.

But Karigiri has a new Director, Dr Abraham Joseph, or 'Uncle', as he has been affectionately called by generations of staff and students at CHAD. As former Head of CMC's Community Health Department, he has transformed CHAD's training and community programmes. Responding to signs of the times, he is now working with staff and others at Karigiri to find a new role for the institution. But how? The rehabilitation, orthopaedic, research and training units are still as much needed as ever. Dermatology has always been an important element in the medical care of people with leprosy. The hospital is today exploring ways in which it can use its existing expertise and its resources to address particular needs in the communities it serves. But Karigiri has always been more than just a hospital. Its international reputation is due as much to its mission to a group of people who were already, in Jesus' time, stigmatized and excluded by society and for whom – on that account - Our Lord himself had a special concern. In exploring new directions for the institution, Uncle and his team have a vision. The Karigiri of tomorrow, they believe, must address the reality of needy people in the communities where they live. More specifically, it must keep faith with Karigiri's ethos by prioritizing marginalized groups, and those who may not be reached by other health and development initiatives: the disabled, for instance, or the mentally ill, or people with HIV/AIDS. This section introduces two CHAD alumni, working in the Community Health Department at Karigiri, who are trying to make this dream a reality.

Sushil John was a 'campus kid'. He grew up in Vellore, trained at CMC, and did his MD in Community Medicine at CHAD. His wife Rikki, a paediatrician, had a commitment to work for two years in Nepal, and that was what took the couple to the United Mission to Nepal (UMN) hospital in Tansen, in the mountains to the west of Kathmandu. It was not easy: Maoists were sometimes active in the area, there had been small bombing incidents, and there was a curfew at night. Field visits were completely stopped due to Maoist activity

in the latter half of their stay in Nepal. All the same, they loved it. "There is a real need there," says Sushil. "People would come miles and miles to go to the hospital because they would know there was hope." Hope of what? Well, this was only a secondary hospital, run partly on short-term staff: but people would go to the tertiary hospital down on the plains and they would find no staff and no facilities or equipment. Here you knew you'd find somebody to do their best for you. When the bond was completed, the couple came back to Vellore so that Rikki could do her MD: but they hoped they would be able to return as soon as possible.

As a community health specialist, why did Sushil opt to come to Karigiri rather than returning to CHAD? Staff don't enjoy the benefits available at CMC in terms of health care, children's education, pensions, insurance and so on. Well, he says, he really wanted the challenge and the new experience. He saw a community health post advertised, he'd heard that Dr Abraham Joseph was coming to be the new Director, and he knew the intention was to expand the community health focus.

But it was in CHAD, initially, that he caught the community health bug. "I love the concept of community health," he says. "It's just so interesting and real. Tertiary care often makes health look quite simple, as if it's just the absence of diagnosable disease or disability. But health is a very complicated thing. The beauty of community health care is that it acknowledges this and attempts to address the various needs of a person who seeks health care".

"I have this dream," he says. "I don't think CHAD has thought through its long-term relationships with the mission hospitals where its alumni serve. But supposing each CMC batch were to adopt a mission hospital, and the members committed themselves to keeping some kind of contact as the years went by, maybe visiting once a year, or taking responsibility for some kind of training or partnership. Part of CMC's role has always been to support these hospitals, and I think it would be a very good if people who go into other areas of medicine were to find ways of honouring that commitment."

Will he go back to Nepal? Well, maybe. The political situation is difficult, and who knows what will have happened to the hospital in Tansen by the time Rikki finishes her MD? Living in isolated, difficult places presents problems with children's schooling. Yes, the need is great: but the need is there in Karigiri too, and it is exciting to be involved in developing new approaches to community based health and rehabilitation. We shall see. Or, as they say in Tamil, pakalaam.

Sushil's boss, Head of the Community Health Department at Karigiri, is Dr Gift Norman, who appeared in the first edition of this book, published in 1989, the intrepid motorcycling community health physician, roaring around the dusty tracks of the Palamathi Hills to attend his remote mountain clinics. In the years between, he spent three years in CHAD followed by eight years in South Africa, at first teaching community medicine at the University of Transkei in Umtata, and then in East London, as co-ordinator of a MPH programme. It was a time of massive change in South Africa. The apartheid structures were collapsing, the first democratic elections were taking place, and new affirmative action laws were creating pressure to train new cadres of public health personnel. The government was completely committed to developing primary health services, and there was a shortage of experienced people to do it. It was a fantastic experience, says Gift, and the lessons he had learned in CHAD and in the Palamathi Hills were invaluable, both in terms of developing community health thinking in another context, and of setting up and managing community based teaching programmes that the universities in South Africa were developing at that point in time.

Returning from Africa, he was offered a job in the teaching job in the Dept. of Community Health in CMC. The campus was a familiar, agreeable environment, and the benefits were good. It was a great opportunity to get back into CMC. "I almost did," he says. "But then I was looking for a more challenging environment – an environment that would give me more freedom and independence to develop new programmes on my own. I also knew by then that Dr Abraham Joseph would probably be going to Karigiri as Director, and having worked with him earlier, I knew we would be in for an exciting time, building up a new programme".

As head of the Department of Community Health, he brings new perspectives and a wealth of experience, not only of community based health care practice, but of different approaches to training and education: a major priority at Karigiri. The focus of the programme will still be on leprosy and its consequences, but they are hoping to develop a broader and more integrated community health programme, targeting tuberculosis, mental illness and community based rehabilitation as well: all of them challenges that can easily be overlooked in the traditional community health agenda. In South Africa, the AIDS epidemic is spreading faster than anywhere else in the world, and this has made Gift particularly sensitive to the plight of people with HIV.

"My main emphasis is on development," says Gift. The department is currently working in three development blocks, setting up self-help groups for people with disabilities that tend to be stigmatized within society, and who can easily fall through the net in terms of

mainstream health programmes. They now have fifty-six such groups with two major focuses. The first is income generation, including skills training, micro-credit schemes, and facilitating members access the government benefits they are entitled to. The second is one of mutual support of each other.

However, the climate in which they are working is more difficult than it was ten years ago. The leadership in the panchayats is often subject to religious and political pressures. Programmes initiated by Christian institutions may be viewed with suspicion. "But my job," says Gift, "is to love and care for people who are in need, not to try and convert them".

So the problems are great, but the possibilities are exciting. What the Karigiri community health team is trying to develop is something quite new, something that has not been done before. It may be years before we see how it all works out. And that is reason why this section is called 'watch this space'.

What they share

Manoj Kurian, Arvind Kasthuri, Glory Alexander, Sushil John and Gift Norman: their lives have taken different courses, but there is much that they share. For a start, they all believe that they owe much to their training. Again and again, as one talks to them, the same themes crop up. First is a passionate belief in what they are doing. Then there are the values of self-discipline, thoroughness, teamwork and professionalism. There is the commitment to personal integrity, in a context where corruption is sometimes endemic. There is the ethos of CMC itself: its founder's dedication to the poor, her roadside clinics, and her scathing attitude to those who sit cosily in their clinic and wait for the patients to come through the door. In the next chapter we shall meet five people whose stories are held together by a common commitment to working, in very different ways, but in one particular geographic environment.

Chapter 6

AGENTS OF CHANGE

'Can anything good come out of Nazareth?'

John 1:46

Tamil Nadu is one of India's most prosperous states, its health and social indicators among the best in the country. For idealistic young people, drawn into community health because they want to go where the need is greatest, this means heading north. Orissa, by contrast, is among the poorest states in India. Here, 47% of the population is living below the poverty line and the health indicators are among India's worst. In Tamil Nadu, for example, 80.8% of children between 12 and 23 months have been fully immunized: in Orissa the figure is 47.7%[4] . In Kaniyambadi, the infant mortality rate is around 40/1000. In Orissa as a whole it is 97/1000, and in one area of the state where CMC graduates are working[5], it is said in a recent year to have reached a staggering 230/1000. Nationally, 8% of the population of India belongs to tribal groups: in Orissa the figure is 22%, plus 16% who belong to scheduled castes. This brings the percentage designated as socially deprived to a grand total of 38%. In spite of (or maybe because of) this, the state has never really been a priority for national government. And yet its mineral deposits make it potentially one of India's richest states. 90% of the country's bauxite is in the tribal areas of Orissa. It is a challenging and contradictory context for young professionals to work in.

But this is exactly why the five people who appear in this chapter have chosen to work here. Drs AV Ramani, Ravi D'Souza and Reuben Samuel are in the capital, Bhubaneswar, working with government or international structures; Dr John and Sr Mercy Oommen are working at community and mission hospital level in the tribal hill areas of Rayagada District.

Backpack doctors

Drs Ravi D'Souza and AV Ramani did their postgraduate study as registrars at CHAD in the 'eighties. After working for a year and a half in eastern Madhya Pradesh (now Chattisgarh), they spent the next four years setting up a health programme for a big development NGO "Gram Vikas" based in Berhampur, in the south of Orissa. It was a region of poverty-stricken hill tribes, covering vast areas, with few roads and – for many of its inhabitants – no feasible access to health care facilities. The infant mortality rate was 164/1000. Ravi and Ramani speak of three to four day treks across the hills, their backpacks loaded with medicines and other supplies; of training sessions in basic health care for

4 figures : National Family Health Survey (1998-99)
5 Figure quoted at Board Meeting of Asha Kiran Hospital, Lamptaput

health workers living at the back of beyond, several hours away from back-up or referral facilities; of the stigmatisation of tribal people and the prejudice tribal people often encounter within the health system; of the incompetence and neglect so many experience when they do manage to get to a hospital or clinic; of the low self esteem and fatalism that go with it; and of the preventable deaths that result. Each of them would travel in this way for ten to twelve days out of every month, almost always separately. It was not an ideal way to start a marriage: but it did provide them with an irreplaceable fund of practical experience in setting up and implementing a community based health service in some of the most remote and deprived areas of India's poorest state.

A Death in the Dispensary by AV Ramani
The Rediff Special, www.rediff.com

Subhashi died quietly and without fuss. A thirty-year-old woman from Tinighoria village in the Kerandimal hills of southern Orissa, she had been coughing for six months before she was brought to our little dispensary. Too ill to walk, weakened by anaemia which caused her feet to swell up, she had an air of quiet acceptance about her. Examination showed that her lungs were extensively damaged, probably by tuberculosis. Her sputum showed numerous acid-fast bacilli, the deadly mycobacterium that causes TB.

We started her on the appropriate drugs, which can act almost miraculously. We also explained to her husband that she needed blood and oxygen, both of which we did not have. These were only available at the large medical college and hospital in Berhampur, about 10km away. But he was adamant. He did not want to take her. He seemed to think he had wasted enough time and effort already bringing her to Mohuda. 'I only brought her because the villagers forced me to,' he grumbled.

Subhashi was extremely cold, and spent most of the next day in the sun. At 10.30 that night, she woke up to go to the toilet. By the time she returned, she was out of breath. We put her back to bed and propped her up. Once more we asked her husband to allow us to take her to Berhampur. Once more he refused. He said she was going to die anyway so there was no use wasting more time and money on her. Her daughter fast asleep beside her, Subhashi lay there listening to us arguing and getting angrier. Suddenly she stopped breathing. We tried to resuscitate her, but I knew it was futile. Was it anaemia and TB that defeated her? Or was it something else that made her give up the will to live?

Even in death, Subhashi's face wore that same look of calm acceptance. How did she remain so? I do not feel calm when I think of her. Nor can I accept her needless, lonely death. Is there a lesson I must learn from Subhashi?

Improving the system

The other thing it gave them was a feeling that no grassroots community based health programme, however dedicated and efficient, can ever achieve sustainable improvement in health care when the system itself is not working for the people. Governments and international organizations claim to be prioritising the poor, but interventions are often planned and implemented in ways that are irrelevant to the realities on the ground. It was easy to see why: when you talked to people working at regional, national and international level, you often found that they had little or no experience of the cultural, social, economic and spiritual context their interventions were designed to address. Armed with their experience in Gram Vikas, Ravi and Ramani took the decision to apply for jobs in organizations that would enable them to address grassroots issues by changing the culture of the system itself. For the last six years, therefore, Ramani has worked for UNICEF in Bhubaneswar, Orissa's capital, while Ravi is Adviser, Health Sector Reforms, in the Policy and Strategic Planning Unit (PSPU) with the Health Department of the Government of Orissa.

First Ravi. Along with others in this chapter, Ravi has been part of the team that produced the Orissa State Integrated Health Policy, for which the British government's Department for International Development is to give £100 million, over a period of 10 years. Here training is a crucial part of implementation. "I have been looking at medical education – which is an area which needs much improvement in Orissa. There are three medical colleges in the state, and the government is about to increase their capacity by 50%. So this might be a good time to change things. One of the things that needs to be done is to make the training more oriented towards community health. In spite of the realities on the ground, none of the three medical colleges has a well-functioning department of community health. You see, in Orissa (as in many other places), medical professionals tend to regard public health as a low-status occupation: they'd rather be doing surgery or ophthalmology or hospital obstetrics,which are high–profile and financially rewarding."

'Over the last few years the quality of medical education in the state has declined. There is a widespread dissatisfaction with the quality of patient care expressed by patients, community leaders, senior bureaucrats, political leaders and even by professional staff themselves'.[6]

6 ORISSA VISION 2010 – A HEALTH STRATEGY:
The Orissa State Integrated Health Policy, p.96

The same is partly true of NGOs. "The Catholic Church," he says, "wants to build fancy 150-bedded hospitals. But what we really need are simple small hospitals practising family medicine and catering to everyday problems." Orissa has around 1000 NGOs working in the field of health care, but it's really only for the mission hospitals that health is the main entry point. The others focus primarily on other issues (poverty, for instance, or development). That means the health component tends to be small and limited. Training is urgently needed, but this is not generally recognized, partly because there are few successful models among the NGOs for people to emulate.

Another major issue is the overriding importance of addressing poor governance, mismanagement and corruption. Donor agencies can help by insisting on mechanisms for the proper administration of funds. The 1999 cyclone was a case in point. "It took people completely by surprise," says Ravi. "One minute everything was OK, the next your house was full of water and there were trees blowing about the road like bits of scrap paper. On the coast, whole villages were washed away in minutes. For some days, Bhubaneswar was completely cut off from the rest of the country."

Ravi was with OXFAM at the time, and the UNICEF building, where Ramani was based, was the only place where everything still worked. So the donor agencies and large NGOs set up a cyclone response office there, and Ravi assisted in mapping the short and medium-term programme of coordinated disaster relief. "Everybody knew what had to be done," he says, "and it all went incredibly well. But then, when the urgent phase was over, all the donor agencies left. And a lot of the money they hadn't spent they dumped on small NGOs that didn't know how to spend it. So the NGOs rented nice places and bought new vehicles, but now things are back to what they were before the cyclone."

Now Ramani, who for the past six years has been health adviser to UNICEF in Bhubaneswar. Working at this level, Ravi and Ramani are nervous about being co-opted into the culture of money and consumerism that they believe to be incompatible with a commitment to the poor. In contrast to most people working at this level, the family does not own a car, so in the morning, after breakfast, Ramani leaves home in a cycle rickshaw. Her work is carefully targeted. In Orissa, the biggest threat to health is malaria. It is the worst affected state in India. Malaria in pregnancy is a particular problem, because it is associated with low birth weight babies, and these are the most likely to die in infancy. She has therefore been responsible for initiating a statewide programme to provide all pregnant women with chemoprophylaxis against malaria. Another major problem is that such large parts of the population have difficulty in accessing health care. This may be due to distance

or lack of transport; but on the other hand, it may be a matter of not knowing what is available, and not being aware of what they have a right to expect from health services once they have made contact. A second of Ramani's programmes, therefore, is to do with access awareness, and of making elected representatives aware of their rights and responsibilities in relation to primary health care services.

In her cool, well-organized office at UNICEF, she talks of the challenge of bringing international principles to bear on government and NGO activity in Orissa. On the day I visited her, she had kicked off with a long meeting with CARE International on monitoring and training. Then there was another meeting, this time with the British government's DFID, to discuss an action plan for an MCH (mother and child health) project. With other colleagues, she reviewed a new video documenting how adolescent girls (Meena groups) have organized themselves, with UNICEF's help, to take on issues of domestic abuse and trafficking in women She cleared up some bits of bureaucracy from the Delhi office. She had a discussion on how adults learn with a colleague who was planning a programme on maternal and newborn care. She checked over the translation of a pamphlet on polio, written in Hindi and then translated into English and from there to Oriya. It will then be translated also into Urdu. When I left she still had a couple of administrative things to do. The next day she was travelling, via Bombay, to a Government of India review meeting in Goa. It is all a far cry from trekking over the hills with a backpack full of medications, or sitting in OPD at CHAD: but it is those formative experiences that give both Ramani and Ravi such credibility in their present jobs.

The same applies to Dr Reuben Samuel, trained as an epidemiologist, formerly of CMC's Virology Department and of CHAD. Reuben is also based in Bhubaneswar, and working as the World Health Organization (WHO) Liaison for Orissa and Health and Social Sector, and Coordinator for the United Nations Development Programme (UNDP) in Orissa. He is energetic and good-humoured: both of them essential qualities for his work. Among many other things, Reuben has a responsibility for establishing multi-disease surveillance systems in various types of health sectors and levels of the health system in Orissa. He is also piloting initiatives for community based rehabilitation of the disabled; reducing the risk of HIV among migrants and their families; and strengthening emergency health preparedness and for supporting the implementation of various WHO and UNDP programmes in the state.

One of his major roles is to build technical capacity for public health and hospital information systems in the state, with greater access and ownership by the community. To do this UNDP is working increasingly at local level, setting up panchayat and block-level

computerised information kiosks. WHO is also strengthening information access to remote health facilities by establishing Internet facilities at primary health centres, the idea being for PHCs to be linked with medical colleges and with institutions such as ICMR, the Indian Council for Medical Research. India is a pilot site for this UN project, which is currently proving particularly effective in the implementation of TB and multi-disease surveillance programmes.

"It's all very much like the work we did in Virology and at CHAD," he says. "I shall never forget the teaching we got in CHAD: the grounding given by Dr Abraham in management of public health programmes, the excitement of JP's classes on epidemiology, and Dr Sara's advocacy for field work. We also did consultations for WHO when we were there. But in Orissa, public health expertise is very poor compared with Tamil Nadu, none of the medical students have any background in public health, and the departments of Social and Preventive Medicine are full of people who are yet to realise or utilise their potential. So we help with epidemiology training for medical colleges, and on facilitating hands-on experience for interns on disease surveillance during their three-month block postings."

Is this the kind of work he wants to do forever? He thinks for a minute. "The need here in Orissa is huge," he says. "In the South they just don't realise how lucky they are. But I can't complain. That was why I came here in the first place. The problem is that I am basically here as a technical person. What I actually spend my life doing is pushing, and negotiating, and seeing how the system can be made to work better. In Virology, more than in CHAD, I was encouraged to think in this way and work through the system at various levels, and it was useful. OK, my heart is really more in research than in this: but I am good at implementing things as well. What I would really like to do in this situation, here, is to develop a core group of people who are interested in public health practice and epidemiology. We've all been helping develop the Integrated Health Policy & Strategy, and we are hopeful that significant initiatives will come out of that."

This conversation is taking place in Ramani and Ravi's peaceful house in Bhubaneswar. "One of the problems," says Ramani, "is that we're considered "outsiders" here, because we're not from Orissa, so there is some reluctance to accept anything we advise or recommend. Also because they see us as talking on behalf of "international" organizations, recommending things that are not relevant for or possible in this State, which is not true in most instances. "But it's also because of the low status of public health generally," says Ravi. "Look at us – when we worked with NGOs, that was regarded as work that no one

else wanted to do. Now that we are working at a higher level with the government and international agencies, they see the possibilities that open up with qualifications or experience in public health."

Do they think the training they got at CHAD stood them in good stead? Well that's another matter. First of all, as a training environment, CHAD is partly a victim of its own success. Kaniyambadi is really no longer representative of India as a whole, and young health professionals looking for a challenge may not find it in the reality they are exposed to there. The emphasis now is on whittling away at morbidity and development statistics in a particular area that is already an island of excellent practice. There is very little discussion of the Indian and global political context of health care generally, and not many attempts to engage with the problems of implementation faced by national governments. And yet CHAD has this extraordinary network of alumni, many of them in need of support, and many with much to offer to discussions about future directions. Rather than just asking them to come back for re-unions or celebrations, why don't they invite them back to advise on policy matters? Why don't they come and see for themselves what we are doing? The mosquitoes arrive, the Samuels leave, and this conversation is over: but the issues will not disappear. The next section introduces two people who are trying to address them from the other end of the spectrum of care.

Basic principles

Media and aid agency reports of the 1999 cyclone make it sound as if the whole of Orissa was affected. In fact, the mountainous tribal areas of the interior were largely untouched, and it was the more prosperous coastal plain that suffered so spectacularly: a discrepancy that is consistent with the general view that Orissa is the coast, while the majority of the state (where the worst of its problems are) is largely invisible. It is to this region that Dr John and Sr Mercy Oommen came in 1993, when they left CHAD and CMCH for Bissam Cuttack Christian Hospital in Rayagada district.

Today, Mercy is principal of the nursing school at Bissam Cuttack. She is small, warm, calm and extremely well-organized. She and Johnny came here together, newly married and straight from Vellore, in 1993. As the only MSc nurse on the staff, she quickly found herself taking a lead. In the past ten years the school has doubled in size, and become one of the most sought-after in Central India. They have just sent two nurses off to Vellore to do their BSc in Nursing. But in spite of many requests, she has so far refused to take nursing students from outside Orissa. "This is one of the only mission hospitals in the state that has a school of nursing, and Orissa needs all the new blood it can get," she says.

Bissam Cuttack nurses serve in mission hospitals all over the state, particularly in the tribal areas, coming back for training and advice when they need it.

The obvious next step is to expand the school by starting a BSc course, in addition to the normal diploma and certificate courses. Then they would probably have to go national and take people from elsewhere. But Mercy also longs to go back to college herself and do a doctorate. The problem is finding somebody to take over from her. Difficult as it is to get doctors to come to the more remote areas, it is even more difficult to find well-qualified nurses.

Johnny Oommen's brief was to set up a Department of Community Health in the hospital. What had drawn him to Bissam Cuttack was the fact that the level of need was so high, particularly among marginalised tribal people. And so MITRA, the Madsen Institute for Tribal and Rural Advancement, was born. Today, it works in 48 villages (a population of over 10,500), helping tribal village communities to undertake their own interventions in the areas of health, education and development. The department is also involved in training, consultancy and operational research.

Johnny himself is a tall, leggy, intense forty-year-old, all elbows and knees and long, expressive hands. He is wearing a surgical collar: deeply uncomfortable in this heat, but the bones in his neck were giving up the unequal struggle and he has recently had a disc removed. No preliminary formalities: we are barely through the door and we are discussing basic principles.

What is community health care? "It's impossible to pin it down. You think you've got it, and then you lose it. Really, community health isn't a type of project, it's a way of thinking. It depends on the circumstances, the time, all the people involved, your faith if any. Whenever you try to grasp it, it seems to fall apart in your hands. Of course it's broadly true to say that hospital medicine takes place in a clinic or hospital, with needy people coming in through your gate to see you; that it's basically focused on the individual, and its aim is to treat diseases. In the same way, you can say that community health is directed at a geographical area, focused on a group, and its aim is to improve the overall well being of the people. Community health happens where the people are, and not in a particular institution. These are the principles we've gone along with since the late seventies."

"But in reality this is an over-simplification, because it grossly underestimates the gravitational pull of institution-building. So many wonderful people went into community health inspired by the vision of Alma Ata, then ended up building hospitals. Then the hospital would eat up more and more staff-time, and require more and more facilities and beds, training and management input and so on; and quite soon they found themselves mobilising resources and training staff to feed the institution and not the outreach programme. But by that time it would be too late.

Once upon a time there was a fishing village by the sea. Just off the coast were some dangerous rocks where ships regularly got wrecked, particularly at night. So when this happened, the coastguard would ring a rescue bell, and any villagers who happened to be around at the time would come out and get into their boats, and row out and rescue the drowning sailors. They would take them home, dry them out and give them a bed for the night. They were happy to do this, they saved many lives, and life went on like that for hundreds of years. Then one day they got a new village leader, who said, 'this isn't a very efficient way of doing this. Why don't we have shifts, so that somebody is always available to go quickly?' So they did, and it did speed things up. Then the leader said, 'rather than taking them into our own homes, which are crowded with our own families, why don't we build a nice comfortable guest house for them to stay in, with a restaurant where they can eat?' So they did, and this guesthouse became a favourite place for villagers to go in the evening, and some of them became cooks and some became gardeners and others went off to college to learn the catering trade. Then one night, when the duty shift was inside with their friends enjoying themselves, and cheerful music was pouring through the window, the coastguard's rescue bell rang out over the cliffs. But everyone was making so much noise that they didn't hear, and all the sailors drowned.

"This is what happens to so many community health initiatives," says Johnny. "They set out with a vision, and a clear idea of what they are there for, and then the institution-building starts, and before they know where they are they've lost sight of the goal. But is running the OPD the goal, or is it just a method of reaching it? Of course we have to do training: but is training the objective, or is it a way of getting to where you want to be?

"In a way, this is what has happened to us. I spend more and more time these days going out and doing training programmes for other institutions, and less and less in the field. But I don't think we are unique. It seems to me that any community health initiative has a life span of about ten to twelve years, and then there is a crisis. Either you've achieved what you want to achieve and it can survive without you, or you've realised you can't

achieve it. You start asking, why are we here? Have the structures we've created replaced the vision we started out with? Isn't it time to move on and pitch our tents elsewhere?

"The fact remains," says Johnny, "that you can sit under a tree and practice the hospital approach, or be a neurosurgeon and have a community health approach. What we need is a paradigm shift in our understanding of health care in the community. We need to move from a bio-medical model to a socio-epidemiological model that takes in the whole context of people's lives and what they want from them." He pauses. "But the problem is," he says, "that we're not the people we were when we started out. When you're twenty-five, it's easy to say 'we'll pack up and go somewhere else'. When you're forty, it's much more difficult." Now we are going to look at two initiatives that illustrate MITRA's vision of doing community based health care in a tribal area.

Proud to be adivasi

Judhisti Saraka is village leader at Kacha-paju, a Kondh tribal village some 18km from Bissam Cuttack, which nestles in the forest, near the ford of a mountain stream. A former night-school teacher, Saraka and his family live in a squat, low house at the bottom of the village street. In Kondh culture, this is a wide single avenue of red-earth, immaculately neat, fringed by dark, mud-brick houses whose thatched roofs almost touch the ground in front of them. There is no running water in this village, and electricity has just recently reached the villlage in the form of street lights. Halfway down the street, with its mass of orange flowers, is the shady gul mohar tree, sometimes known as flame of the forest, and next to it, the wooden stake that provides a focus for the animist religion practised by the villagers. It is midday in early May, the temperature is around 40 degrees, and all sensible people, along with their children and dogs and goats and chickens, are inside their houses, sleeping until the heat of the day has passed.

When Johnny and Mercy Oommen arrived at Bissam Cuttack, the village had only a nonfunctioning government school, and no clinic. Health and development people would come and go. Somebody came and 'did' literacy, and then went. Health workers would visit, trudging over the rocky tracks with their backpacks, and maybe spend a night before going on to the next village. Getting a medical emergency could involve a three-hour walk, and patients would often be dead by the time they arrived.

Then in 1995, the Community Health Department set up a clinic in another village, and when the people of Kacha-paju went to the inauguration, they saw what was possible and wanted it. "But there is no building, the roads are impassible, the village is nowhere.

How would we get a nurse to come and live here?" asked Johnny. "But we are asking for this," replied Saraka. "We can be responsible for security, we can fix the road, and we can build a clinic that is like our own houses." Within a year, it had happened, and Savithri, a courageous and committed woman nurse from Bissamcuttack, arrived in the village and started training with local woman health workers. Now there are health workers in 15 of the local villages, a mobile clinic comes weekly from Bissam Cuttack, and training sessions are held once a month. Before this, 2/17 births took place in hospital; now a trained nurse attends 10/17 deliveries, and the number of deaths has fallen.

Buoyed up by the success of this venture, and the realisation that you can make things change if you want to, the village leaders looked at their situation again. "Our biggest problem," they said, "is lack of education." If you have education, they decided, your family's health will improve. You will cope better with bureaucracy. Police cannot bully you so easily. In short, your community has a future. "The older generation can't believe how things have changed here," says Saraka. "Now we want the younger generation to grow up knowing that they are not stuck forever with the way things are. What we need are people who can be the leaders of the future, who are proud to be adivasi, but who have the qualifications to gain respect in today's India."

There was a government school in the area, but it had no teaching staff: the teachers would neither live out there nor make the daily journey. There was a new school in town, but it was too far to walk there daily. Very few teachers were able to speak the local tribal language, Kuvi, and so education – when you got there – was in the state's official Oriya language. That meant that tribal children started at a disadvantage and remained that way throughout their schooldays. And so the great idea was born. They would start a primary boarding school, taking small children up to Standard 5, and serving 16 Khond villages. The road was already built. The villagers would be responsible for the buildings. 350 volunteers joined in to clear a space in the forest, and to build the first of the tin-roofed mud buildings that now house the school. And in July 1998, the first batch of 30 children moved in.

The school follows the state curriculum, so that boys and girls can compete with non-adivasis when they go on to the next stage. Apart from that, the aim is to educate the children in their own culture, with familiar food, local religious practices, and their own language. Tuesday is a free day, so that they can go to market with their parents if they want; and the last lesson of every day is agriculture. Standard schools tend to devalue minority cultures, languages and religions: but this school is designed to affirm tribal culture not replace it, and above all to maintain the closeness between children and their

families. All of the young staff are Kuvi-speaking adivasis, apart from headmaster Chandrasekhar.

Bumping along the rocky track, you come upon the school quite suddenly in its forest clearing, with the vegetable garden running downhill towards the stream. It is lunchtime. Some children are spilling out of their classrooms in to the playground, while others are inside reading or playing. There is no running water, no electricity and little furniture. There are pit toilets for the girls, but the boys go into the forest, as they would do at home. Each child has a small attaché case with clothes, a blanket, a plate and an exercise book. No bed, no desk. That's it. The cost per child is Rs5000/- a year, which is about US$100: a sum that is partly met by parents, and partly by private donations.

Were there no difficulties? Yes, hundreds. For example, the night of thunder and lightning and torrential rain, when the concrete mixer got stuck in the forest. The difficulty of accessing appropriate training, and the scary business of learning things by doing them. The lack of water and electricity, and the fact that the nearest phones are 7km away. The textbooks, which all relate to urban areas rather than tribal ones. The attitude of funding agencies, who think they have seen this kind of thing before. 'A boarding school?' they say. 'You'll end up running a fee-paying private school!' The list is endless.

And then there are the political difficulties. Johnny misquotes Brazilian bishop Dom Helder Camara. "If I do health work they call me a saint," he says, "but if I do education they call me a troublemaker." Local Hindu groups are haunted by the fear (sometimes justified) that all Christians are really there to convert tribal people. Mission hospitals they are more or less used to: but education is to do with hearts and minds. "But our message is love, not conversion," says Johnny. "We're not evangelists, and we keep out of politics. But at the same time, you can't work with tribal people for long without realising how deeply marginalized they are. The young people grow up thinking the only way forward is to get out. What's needed is a new generation with a leadership cadre that's proud to be adivasi, and that wants to stay put and claim their people's rights." Hence the school at Kacha-paju. And hence the great pride with which Judhisti Saraka talks of his village's achievements over the past ten years.

People's Malaria Movement

When CHAD opened its doors, it judged that the most pressing need in that area was for MCH. In Orissa, the most urgent health problem is malaria. The state has 3% of India's population. According to the National Malaria Eradication Programme (NMEP) it has around 20% of India's malaria cases and about 50% of reported deaths. Most of Orissa's

malaria occurs in areas similar to that of Bissam Cuttack, among tribal communities living in small, scattered villages with low population density and great geographical barriers of hills and forests. Communication is poor, roads and transport meagre, and health infrastructure inadequate.

How do such communities address the problems of containing communicable disease? The government's NMEP focuses mainly on early diagnosis, prompt treatment with chloroquine and the use of indoor residual sprays such as DDT. But incidence continues to rise because, like many top-down interventions, this one has failed to change behaviour because it has failed to engage with their cultures and beliefs. For example, communities tend to have their own understandings of illness that may not allow for allopathic treatments. There is also a widespread belief that malaria is caused by drinking contaminated water.

The People's Movement Against Malaria is rooted in the principle that for people to be motivated to protect themselves, they need some shared understanding of the basic epidemiology of the disease, together with a realisation that it is malaria that is causing so much sickness and death. The first step, therefore, is the targeted education of village level communicators; the next is a mass education programme for the whole community. Preventive measures include the supplying of insecticide treated mosquito nets (ITMNs) combined with a supply of neem-oil based repellents. Together with back-up laboratory services when needed, and more conventional interventions leading to early clinical diagnosis and prompt treatment, this village level, people-centred, education-based programme is underpinned by a village-based health management information service designed to provide data for monitoring the situation. Twice a year it becomes the focus of a big village celebration, or mela. This, says Johnny, is a wonderful day, bringing together the whole community for a celebration dipping of the nets.

Since the birth of the People's Movement Against Malaria, the MITRA team has carried out training and advised on implementation in other centres and districts in Orissa. There is no 'divine path' to malaria control, and every situation is different. Nevertheless, it does seem to offer a highly adaptable model that can be up-scaled or downscaled. "OK," says Johnny, "it's not perfect. There are lots of loose ends. And sure, most of the staff have trouble spelling chloroquine. But that's OK. They've all had malaria themselves, and they've all known someone who died of malaria. Our role has been primarily as dreamers, trainers and consultants, but they have faced the problem from the inside. We're living in a time when interventions tend to be more and more top-down or centralized, and solutions more and more scientific and technical. Yes, we must arm people with the knowledge and skills discovered by scientists all over the world. But the real joy of this movement is that the

concept itself is a return to the vision of Alma Ata, where the people's health is placed firmly in the people's hands."

Agents of change

The development movement of the last quarter of the twentieth century was often characterised by a distrust of big institutions, fuelled by the writings of such gurus as EF Schumacher and Fritjof Capra. 'Small is beautiful' was very much in the spirit of Alma Ata. However, it translated readily into a general anti-institutionalism that has made it difficult for civil society to establish an effective community-based response to corruption at local or national level, and to the top-down initiatives favoured by international organizations. In this chapter we have met a group of friends, in one particular Indian state, who are trying to do something about this: in Bissam Cuttack by building up grassroots institutional responses to particular problems among exceptionally deprived groups of people; in Bhubaneswar by taking grassroots community health experience into the heart of international, national and regional organizations and trying to influence their thinking from within. I do not want to end this chapter without saying that I think this kind of pincer movement deserves much closer analysis than I am able to give it here.

Chapter 7

TRANSFORMING LIVES

I find that thy will knows no end in me
And when old words die out on the tongue,
New melodies break forth from the heart

Rabindranath Tagore, Gitanjali XXXVII

'Every generation has its own road to tread'

Dr George Chandy is Director of the Christian Medical College, Vellore, and Ida Scudder's vision is a cornerstone of his thinking. "Aunt Ida," he says, "was concerned with teaching and training, and with caring for suffering individuals. But she was also concerned with people's social and cultural life: the prejudice and oppression that stopped women accessing health care, the poverty that killed babies and children, the preventable diseases that ruined so many lives. She dreamt about transforming lives by reaching out in the spirit of Christ to the communities round about, then to India, and then to the world."

"If we're talking about CMC's vision," says Dr Chandy, "it's here that we should begin. What does it mean to us as an institution, working in this context, this century, and in this particular socio-economic climate, to seek for transformation 'in the spirit of Christ'? Every generation has its own road to tread, and a hundred years ago, the answers would have been different. But for me the framework for a new paradigm comes from Jesus, who responded to God's call, gave of himself, and became the living example of a new way of caring and healing. It's that example we have to follow when we are creating systems that have the capacity to transform."

At the moment, though, India itself is going through an extraordinarily rapid process of social change. Technology has made the world a smaller place, and the widespread availability of TV has fanned the desire for other ways of life. Social and family structures are tottering. Consumerism affects everything, causing education and health to be seen as big business, or alternatively as commodities to be paid for. With this widespread collapse of traditional value systems, George Chandy sees CMC as a place to emphasize the personal, to proclaim – through what it does and the way it works - the value of human life itself.

And how does he see community health fitting into this vision? "Oh the community health programmes are crucial," he says. "They are our conscience. It's very easy, if you work in this hospital, to become cut off from the suffering and pain and squalor that's the everyday experience of many of our patients. My chappal seller died recently and I went to his house: and I realized then how much needs to be done to improve the lives of the poor people outside the campus walls. And yet it was there (and not our wards and clinics) that Aunt Ida saw the most urgent need for transformation."

But the times have long gone when Christian organizations can expect to create change on their own. First and foremost, in the 21st century, 'transformation in the spirit of Christ' means outlawing triumphalism. Completely. New paradigms of healing go hand in hand with new paradigms of mission, and these are characterized by collaboration, facilitation and resource sharing, and by listening to and respecting the view of others. George Chandy hopes, therefore, that one of the hallmarks of his time in office will be a sustained attempt to build trust between CMC and Vellore Town itself. The community health programmes are absolutely crucial partners in this project, and in the business of demonstrating, on the ground, what it means to work for transformation in the spirit of Christ.

Christian ministry has always prioritized the need for working for transformation in a sick and suffering world, and building systems designed to achieve that aim. George Chandy's words, together with his warning against triumphalism, suggest that new times and new contexts may demand a re-evaluation of those systems. In a nutshell, you can't do it differently and expect to remain the same yourself. In the light of the thoughts expressed by people who have appeared in previous chapters, this final chapter suggests some possible responses to Dr Chandy's challenge to develop a new paradigm of healing mission that is framed by the life of Christ.

Starting from where you are

This section looks at some of the new priorities and emphases that have already been identified by CHAD staff and faculty. These relate to the changing health care needs of communities, and to the expanding demand for training at the regional and international levels.

First the health care needs of communities. Dr Chandy (along with many others) has referred to the breakneck speed of social change in India today. Urbanization, consumerism and the communications revolution have brought about changes in family structure and diminishing respect for authority figures, and communities are losing some of the traditional

mechanisms for dealing with problems. This has led to a sharp rise in suicide and domestic violence, a growing number of elderly and infirm people with nobody to look after them, and a newly independent generation of adolescent boys and girls. Tuberculosis is still a major challenge. Lifestyle changes have altered morbidity patterns, with an escalation in such conditions as diabetes, hypertension, cancers, alcoholism and obesity. In addition, there is a set of issues relating to reproductive and sexual health, and the need to control the spread of HIV.

Chapters 1 to 4 have explored the programmatic implications of these issues for service implementation, research, and training and development at CHAD. The coming years will see new responses to the needs of adolescents, and of frail and elderly people. The work of the Family Counselling Centre will expand. Increasing priority will be given to sexually transmitted and reproductive tract infections, and the control of HIV/AIDS. Building on the success of the DOTS, methodologies will be developed for addressing other forms of disease. The health education programme will continue to work creatively with such issues such as tuberculosis, smoking, alcoholism and sexually transmitted infection.

Fifty years ago, government health services in India were just emerging. As a result, health professionals working in non-governmental community-based programmes tended to see it as their role to do it better than the statutory services, creating islands of excellence in oceans of human need. This has sometimes produced a history of distrust and suspicion between the two sectors. Today, health is a major priority for the Tamil Nadu government as well as the Indian one. Only 11% of all health care in India is provided by non-government agencies. The real challenge, as Dr JP Muliyil says, is to assist statutory services in becoming more effective, not to try to do their job for them. Given the current religions tensions, there is a need for Christian institutions, in particular, to created cultures of collaboration, build trust, and work together with government agencies to identify the distinctive contribution that they can make.

For Dr. George Chandy, the building of trust between CMC and government agencies has become an institutional priority. With its epidemiological expertise, its data collection resources, and its reputation for integrity and care, CHAD has much to contribute. For many years now the health information system and the NAHDI programme have collaborated with government services, and the epidemiology team has been called in to conduct independent evaluations of government programmes. The DOTS programme is run in collaboration with government, providing a model for cooperation over other matters.

CHAD's reputation as an international training institution is relatively recent, but it has grown quickly. The expansion of these training programmes seems likely to continue. As a WHO Collaborating Centre, there is likely to be further development in terms of regional training. Existing links with institutions in Europe and North America will continue to expand, and the possibility of new links will be explored.

Four controversies

In recent years, there has been a good deal of controversy about public health, how and where it should be taught, and at what level interventions should take place. Schools of public health, set up to promote a discipline that was once a poor relation in the medical curriculum, have succeeded in putting public health on the map as a specialty in its own right that provides a wealth of career openings today. Many of these schools have grown into large, prestigious and virtually autonomous institutions. But success has come at a price, leading to a widespread concern that the institutionalization of the public health agenda may have created the illusion that clinical specialties exist in a hospital-based vacuum that has nothing to do with the everyday lives of the people.

Glory Alexander, whose work is described in Chapter 5, was a student at CMC before CHAD was born, and as a result, she has no formal training or qualifications in community health. Nevertheless, she is currently running a highly original and successful community based HIV/AIDS programme. "I did clinical medicine," she says, "and that is very individually based. I never really thought about doing community health. But the fact remained that the way I was taught and practiced clinical medicine at CMC was very community orientated. I don't know what it's like today, but in those days an awareness of the community dimensions of health care ran all the way through our training."

It is outside the scope of this study to speculate on how far this would be true of CMC today, but studies of institutions in all part of the world have shown that the price of the schism between public health and clinical medicine has been a gradual decrease in the level of community awareness in the culture of the tertiary hospital. We should look again at Johnny Oommen's words in Chapter 6. "The fact remains," he says, "that you can sit under a tree and practice the hospital approach, or be a neurosurgeon and have a community health approach. What we need is a paradigm shift in our understanding of health care in the community. We need to move from a bio-medical model to a socio-epidemiological model that takes in the whole context of people's lives and what they want from them."

This is a far-reaching debate, concerning the philosophical, ethical and institutional basis of CMC's commitment to community health itself. It is a debate that is currently taking place in health care institutions all over the world. If and when it takes place within CMC, it will inevitably draw in not just the other departments that are working in community health, but the rest of the institution as well.

A second area of debate within CHAD concerns the primary programmatic focus of its work. In 1989 I put together a graphic that demonstrated how the CHAD system worked. At the center of it was a big circle that said 'VILLAGE'. Revisiting it today, several CHAD faculty members commented that, although this was true in 1989, today the word in the circle would be just as likely to be 'STUDENT'. Another murmured dryly that in practice, as far as she was concerned, it should be 'BASE HOSPITAL'. This discussion throws light on some of the difficult choices that have to be made. For example, there is widespread welcome for the increasing use that is being made of the facilities at the base hospital in Bagayam. At the same time, staff at all levels comment on the increased workload at CHAD Hospital, not because they object to hard work, but because it reduces the time they are able to spend in the field. This demonstrates what Johnny Oommen calls 'the gravitational pull of institution-building'. The growth of the institution is in constant tension with the empowerment of communities, with training and service resources increasingly drawn into the maintenance and expansion of the base hospital. At the same time, less and less priority may be devoted to the training of field staff and the development of capacity within communities themselves.

A third dilemma stems from the very success of the CHAD programme. The philosophy of primary health care is rooted in the conviction that priority must be given to the needs of the poorest and most marginalised people. And yet health indicators in Kaniyambadi today can compete with any in India, and the economic programmes have made a real difference to people's ability to manage their own lives. New issues can be addressed only because basic infant mortality and morbidity issues are under control. But this has its problems, because it means that the context in which CHAD is working is no longer typical of India as a whole. In Chapter 6, the Orissa people expressed concern on two levels. First, medical and nursing students may go away from their training with the idea that it's like this everywhere. Second, able and idealistic young people, seriously wanting to serve their country and engage with human need, may be lost to community health for ever because they do not, in this relatively well developed environment, find the challenge and excitement they seek.

One response to this, as former Head Dr Abraham Joseph used to say, is that CHAD does not set out to be a model that can be transferred unaltered to another context. It is there to show people what is possible, and what a well-resourced, established programme with a record of excellence can achieve. Another answer is that CHAD can never be typical anyway. For non-government community health programmes in general, the most pressing problem is the unremitting struggle to be economically sustainable. But CHAD is part of the Community Health Department of CMC, and as such its staffing and financial viability are assured.

In an effort to address this situation, staff have tried to expand the scope of their work into the poorest slum areas of Vellore Town, and into the Jawadhi Hills, an isolated and inaccessible tribal area to the south of Kanyambadi. One powerful message coming from the people interviewed in Chapters 5 and 6 was to do with the need to expand this focus, and if possible to include the more systematic exposure of young people to the areas of greater deprivation served by many of CHAD's alumni.

A fourth concern, expressed by all members of the Orissa group, is that students and interns should leave CHAD with a greater awareness of the global political context of health care today. A quarter of a century after Alma Ata, the ideology of community empowerment is getting more difficult to maintain, while health delivery systems at every level are becoming increasingly centralized and top-down. And yet the spirit of Alma Ata lives on, and there are many stories to demonstrate that this is the case. A young health professional will be far more effective, running a mission hospital, if he or she has some understanding of the systemic issues that are being debated regionally and internationally. For example, how should the insights gained by working with needy communities be incorporated into the strategic and programmatic thinking of governments and international agencies? How may communities be empowered to resist the debilitating effects of privatization and top-down programme design? What can be or is being done to combat endemic corruption? Speaking from the context of the World Council of Churches, Manoj Kurian, (Chapter 5) names this systemic awareness as an issue of universal concern to Christians working in the field of community health today.

Transforming mission

It has been a privilege to write this little book, and to have the opportunity to talk to so many creative and committed people about the issues discussed in it. As Dr George Chandy has observed, Indian society is going through a period of massive change, and the ripples are felt in every home and institution in the land. As for me, I have been a friend of CHAD

for fifteen years, and there are three things that I hope will never change. The first is the astonishing level of commitment, at every level, of its health, administrative and development staff. The second is the sense of being involved in a web of purposeful, committed activity, where the organizational values (although essential) are always subordinate to the human ones, and where everyone – however busy – always has time for a friendly word. The third is the feeling of being drawn into an ongoing conversation, both idealistic and pragmatic, about how a free and generous response to need can be combined with the highest standards of professionalism on the one hand, and on the other, the human values of love, care and intelligent discernment

Is this what it means to be this institution, in this place, at this time? The chapter opened with a call for 'transformation in the spirit of Christ'. As an outsider, it is not for me to say what form that transformation might take. What I have tried to do is to record what the insiders of yesterday and today are saying on the subject, and to set out some thoughts' about the overall context in which new ways and new thinking may be developed. In short, I have tried to consider the signs of the times. The next step is for others. And that is why, as Dr Sulochana Abraham says, 'it is so vital for us to remember our roots, our faith and the vision that inspired this institution long before any of us were born.'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